

3517

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>55 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Jacksonville</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48x-3</b> d. STREET ADDRESS <b>5746 Timuquana Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Marshall ALLEN</b>				4. DATE OF DEATH Month Day Year <b>March 4 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-18-23</b>	
9. AGE (In years last birthday) <b>36</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles ALLEN</b>				14. MOTHER'S MAIDEN NAME <b>Bess WATERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II</b>		INFORMANT <b>(Wife) Olivia T. Allen</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 January</b> , 19 <b>60</b> to <b>4 March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4 March</b> , 19 <b>60</b> , and that death occurred at <b>6:35A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 3-7-60</b>							
ACTUAL SIGNATURE <i>John W. Davis</i>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>					
PHYSICIAN'S NAME (Type) <b>J.W. DAVIS LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-9-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tampa</b>		22d. LOCATION (City, town, or county) (State) <b>Tampa Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> ADDRESS <b>W.W. Chambers 1400 Chapin St. N.W. Washington D.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3518

## CERTIFICATE OF DEATH

03399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Pennington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucille Drummond Appleby</u>				4. DATE OF DEATH Month Day Year <u>March 19 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18 1901</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Educ.</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry D. Appleby</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Bennet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-36-7620</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, retroperitoneal, severe</u> 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of uterus</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u> <u>2 yrs +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral ureteral obstruction due to carcinoma, metastatic</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>March 19, 1960</u> , that I last saw the deceased alive on <u>March 19, 1960</u> , and that death occurred at <u>8:10 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>3921 Ingomar St N.W. Wash 15 D.C.</u> DATE SIGNED <u>3.19.60</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>				PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REG'D BY REGISTRAR <u>MAR 22 60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3519

## CERTIFICATE OF DEATH

64623  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> <b>83X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>905 Princess Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Steve</b> Middle <b>(None)</b> Last <b>Archie</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Company</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen Archie</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Marks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemoptysis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of lung</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>7 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 17, 1960</b> to <b>March 28, 1960</b> , that I last saw the deceased alive on <b>March 28, 1960</b> and that death occurred at <b>2:02A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/28/60</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/28/60</b>		22b. DATE THEREOF <b>Ch. Cenn.</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) <b>Roch. Hall</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arnold Luns Home</b> ADDRESS <b>3116 Patrick St. City</b>		24a. REC'D BY REGISTRAR <b>3/28/60</b> DATE <b>APR 29 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>		24c. REGISTRAR'S SIGNATURE <b>Mr. P. - O.</b>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3456

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03400

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. S.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>1656.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp</u>				d. STREET ADDRESS <u>1823 Kanawha St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carole June Asbury</u>				4. DATE OF DEATH Month Day Year <u>3 - 27 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-14-60</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Stewart Asbury</u>				14. MOTHER'S MAIDEN NAME <u>June Shupp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stewart Asbury (father)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>2 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-27-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 31 60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hantz</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Your files should be retained for a period of 10 years. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Page 4 should be retained for a period of 10 years or removal.

2075374XU2



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Alexander Bartlett</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1906</u>
9. AGE (In years last birthday) <u>53</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Administration</u>	
11. BIRTHPLACE (State or foreign country) <u>Northhamphshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Edward George BARTLETT</u>		14. MOTHER'S MAIDEN NAME <u>Laura Isabell Fredette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1942-1946</u>		16. SOCIAL SECURITY NO. <u>0026-4950</u>	
17. INFORMANT <u>Marguerite Bartlett, same</u>		Address <u>024-7518</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-15-60</u> to <u>3-15-60</u> , that I last saw the deceased alive on <u>3-15-60</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4422 East West Hwy, Bethesda 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>		DATE SIGNED <u>3/15/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE TIME OF <u>3/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. RECEIVED BY REGISTRAR DATE <u>MAR 18 60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

CORONER NOTIFIED AND OK

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





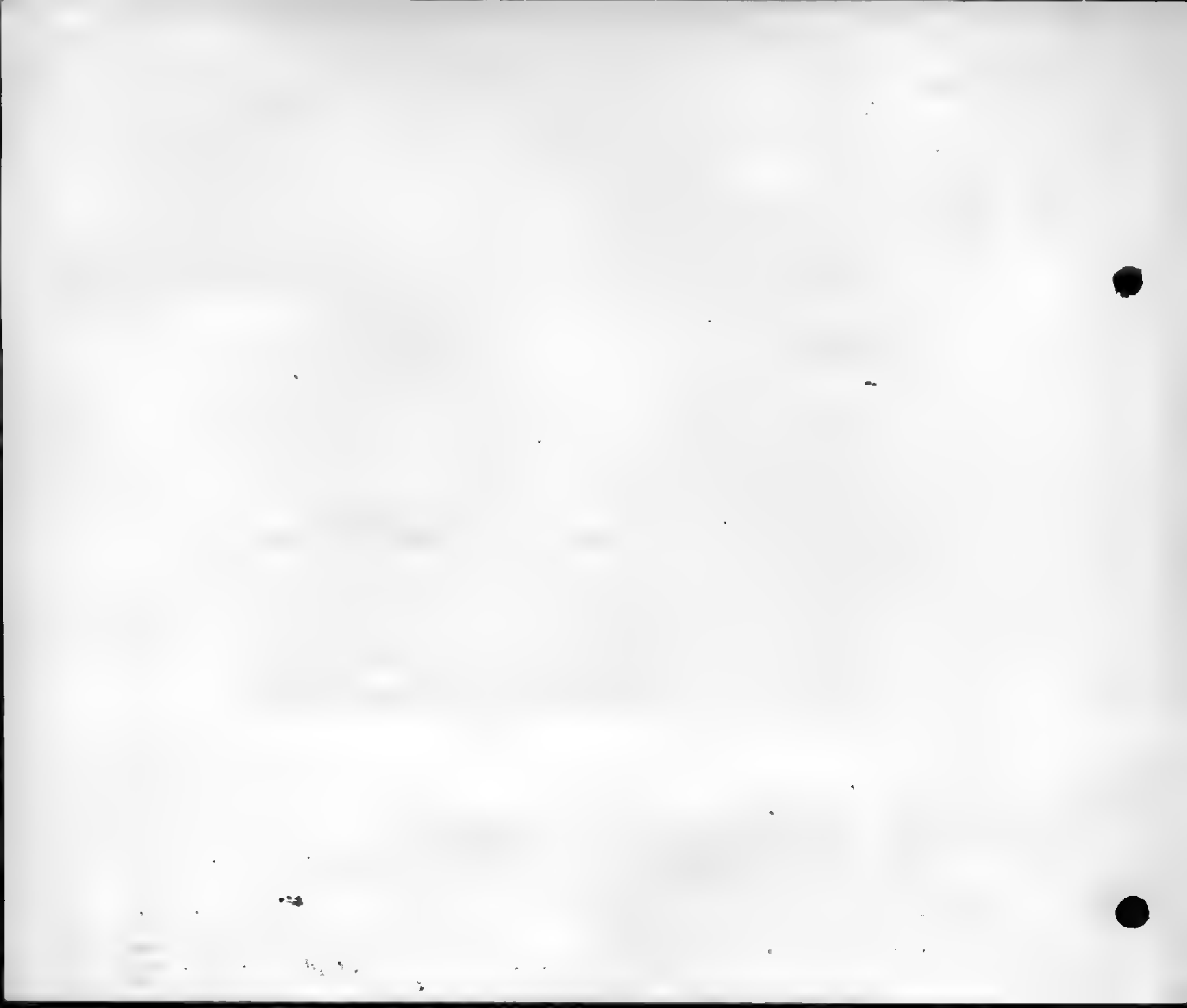
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## 3452

03402

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN TB <u>3 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 Baltimore Avenue</u>		d. STREET ADDRESS <u>6465 16th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Grace</u> Last <u>Bartlett</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23 1876</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery store</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James F. Bartlett</u>		14. MOTHER'S MAIDEN NAME <u>Ann C. Metzger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Edna E. Schlegel</u>		Address <u>6465 16th Ave NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO <u>Arteriovenous aneurysm of left posterior</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/17/1951</u> to <u>3/16/1966</u> that (I) (we) last saw the deceased alive on <u>3/16/1966</u> and that death occurred at <u>  </u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Dr. J. M. Morse</u>		22b. DATE SIGNED <u>3/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. Morse</u>		22d. ADDRESS <u>713 Carroll Ave, Takoma Park Md</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Buried</u>	23b. DATE THEREOF <u>3/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
ADDRESS <u>2901 14th St. N.W. Washington D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03403

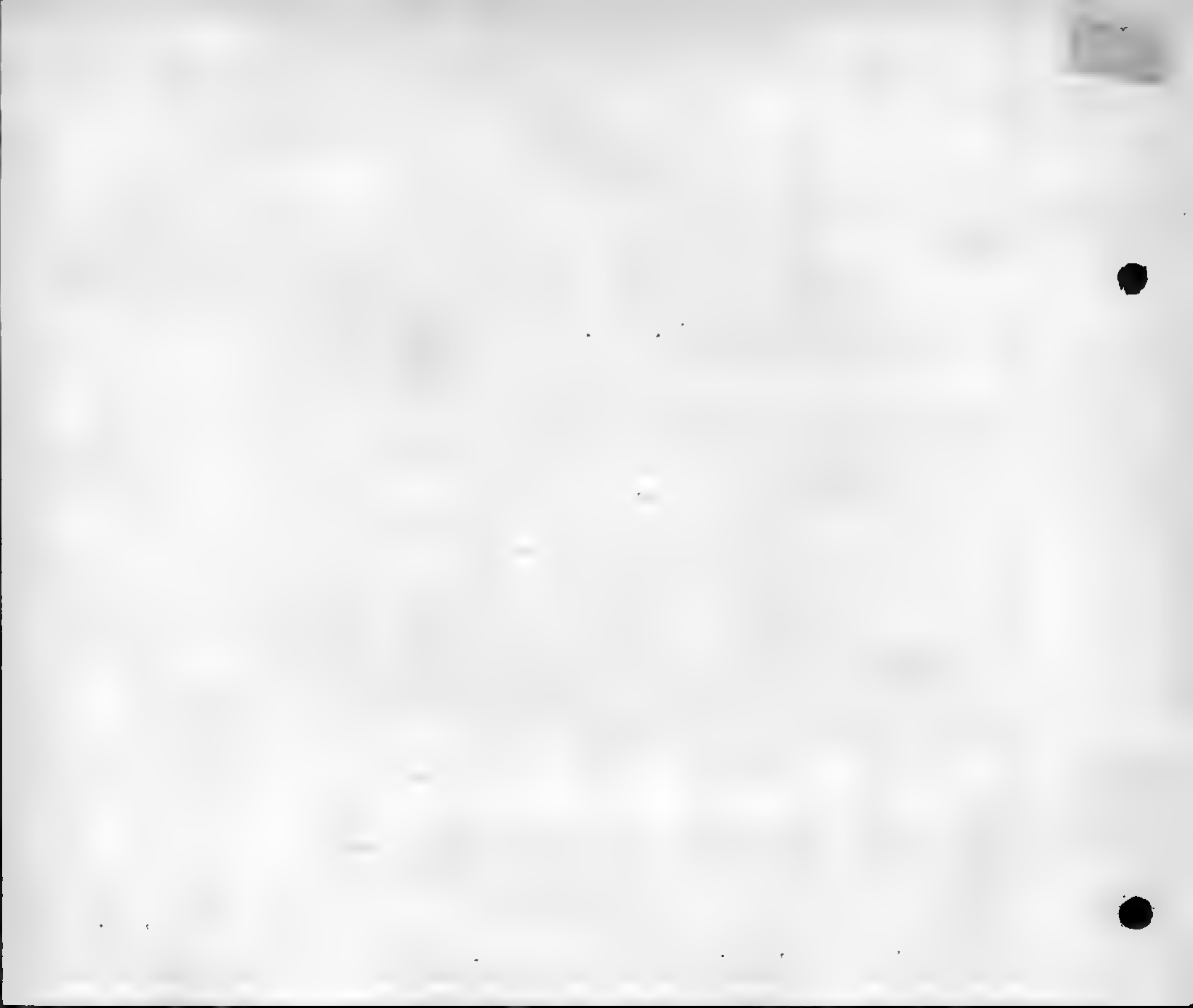
3458

Item 3, Film G-4, 3/21/60 cuc.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN TB <u>5-3-11/18</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. &amp; Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING Md</u> d. STREET ADDRESS <u>1911 ELKART St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VERNAL MARIE Walston Bassett</u>				4. DATE OF DEATH Month Day Year <u>3-6-1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1919</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l. Inst. Health</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES WALSTON</u>				14. MOTHER'S MAIDEN NAME <u>PEARL ASHMORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. Ralph S. Bassett</u> Address <u>Stevens Dec</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause lost. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-6-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Mar 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Catherine L. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event not later than 72 hours after death.

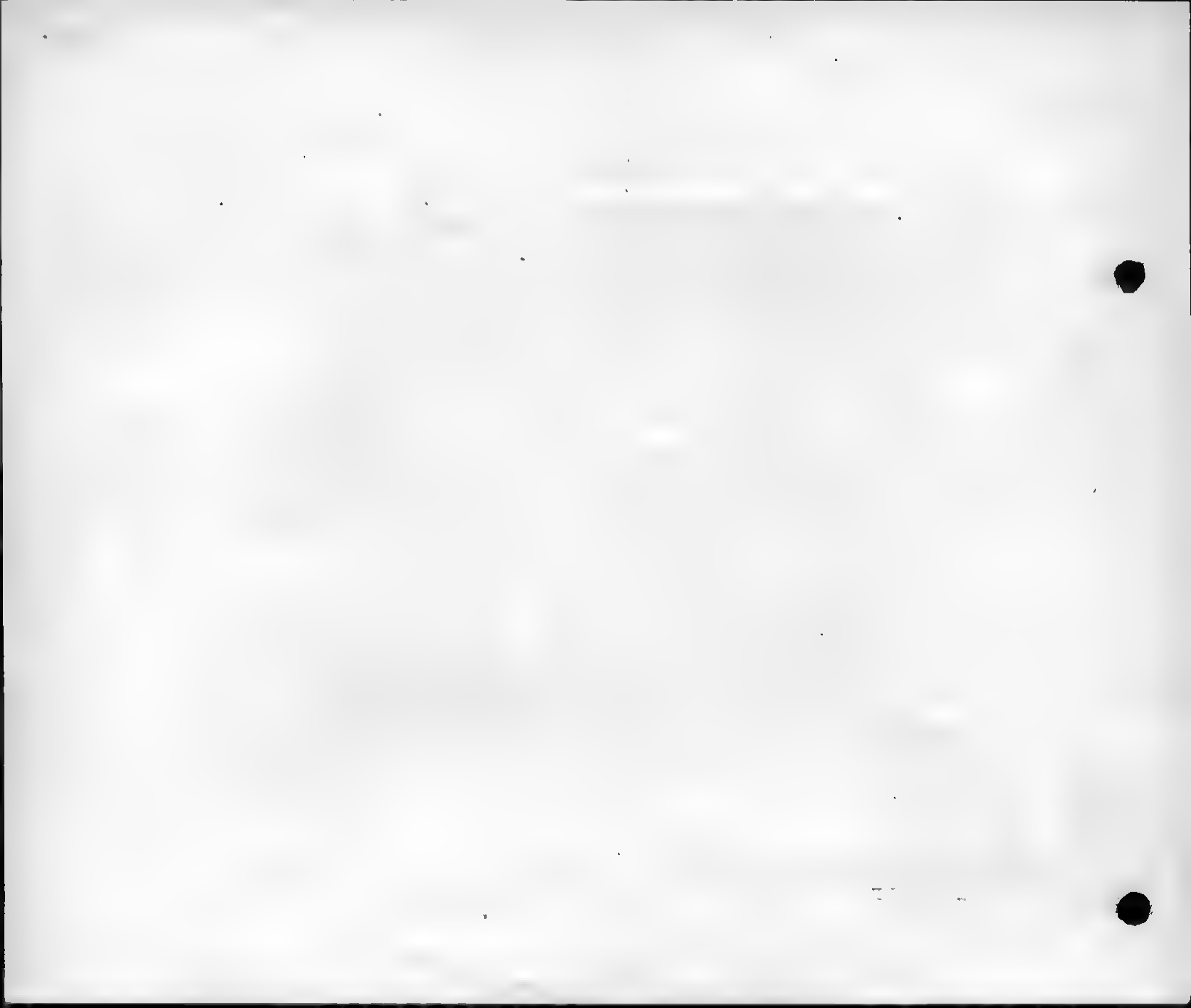
VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3459

13404

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>57 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Ellen Mary Baker</u>				4. DATE OF DEATH Month Day Year <u>March 27 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 16 1934</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Owen F. Gilmartin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Loftus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>100-1-100000</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>HEART FAILURE, ACUTE</u>							
DUE TO (b) <u>RENAL CELL CARCINOMA WITH PULMONARY METASTASES</u>							
DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1956</u> to <u>MARCH 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>MARCH 27, 1960</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D.				22b. DATE SIGNED <u>MARCH 27 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u>				22d. ADDRESS <u>7733 ALASKA AVE N.W. WASH 12 D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>3/30/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co</u>				25a. REC'D BY REGISTRAR <u>2901-14</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>				25c. DATE <u>MAR 29 '60</u>			





3506  
CERTIFICATE OF DEATH

Reg. Dist. No.

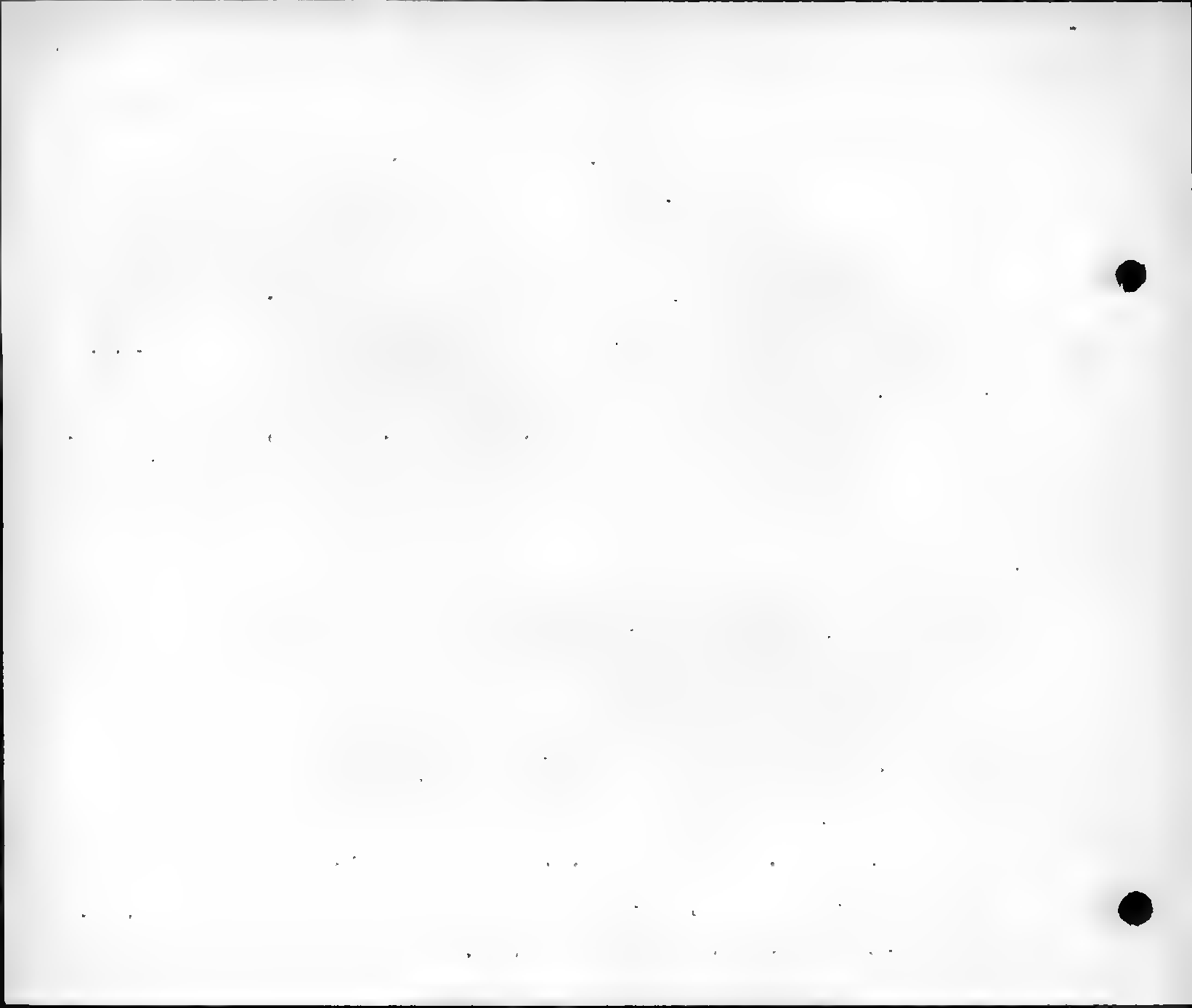
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3717 Decatur Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Harriet</b> Last <b>Beedle</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/31/78</b>
9. AGE (In years last birthday) <b>81 88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>CONNECTICUT</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CLARENCE EDWIN BELL</b>	
14. MOTHER'S MAIDEN NAME <b>CARRIE WHITE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT Address <b>Mrs. Florence G. Mitchell, 3717 Decatur St. Kensington, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tumor, right breast; Malignant?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Feb 2</b> , 19 <b>60</b> , to <b>March 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 5</b> , 19 <b>60</b> , and that death occurred at <b>12:11 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>March 8, 1960</b>	
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.		22. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. J. Jaka</b>	
24a. REG'D BY REGISTRAR DATE <b>MAR 10 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		25b. DATE THEREOF <b>3/11/60</b>	
25c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cemetery</b>		25d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	

1

VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3460

CERTIFICATE OF DEATH

03406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>WASHINGTON D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANT &amp; HOSPITAL</b>		d. STREET ADDRESS <b>2440-16th ST NW</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RANDOLPH H BELLMAN</b>		4. DATE OF DEATH <b>MARCH 9 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-92</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Robert Hall</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>OSCAR BELLMAN</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES I WWI</b>		16. SOCIAL SECURITY NO <b>577-07-5388</b>	
17. INFORMANT <b>MRS KATHERINE POLLOCK</b>		Address <b>13116 ESTELLE RD S.S. MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 21, 1959</b> to <b>MARCH 9, 1960</b> , that I last saw the deceased alive on <b>MARCH 3, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Wm D. Brill M.D.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Wm D. Brill, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-14-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATH</b>		22d. LOCATION (City, town, or county) (State) <b>FTMYER Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm D. Brill</b> ADDRESS <b>Wash D.C.</b>		24a. REC'D BY REGISTRAR <b>Wm D. Brill</b> DATE <b>MAR 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm D. Brill</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3436**  
**CERTIFICATE OF DEATH**

13407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1422 HIGHLAND DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM GODMAN BENDEL</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATENT EXAMINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. C. BENDEL</u>		14. MOTHER'S MAIDEN NAME <u>GODMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>W.W.I.</u>	
17. INFORMANT <u>MRS. BERNICE L. BENDEL</u> Address <u>SILVER SPRING, MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral arteriosclerosis</u>		5 yrs	
(c) <u>Essential hypertension</u>		25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, locality, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Feb.</u> 19 <u>50</u> to <u>March 9</u> 19 <u>60</u> , that I last saw the deceased alive on <u>March 3</u> 19 <u>60</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D. <u>5600 N.H. Ave. Wash. D.C.</u>		DATE SIGNED <u>3/9/60</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT, MD</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>Mar. 12, '60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>Bladensburg Rd. P.G. Co.</u> (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Turner</u> ADDRESS <u>354 Carroll St. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Turner</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.





3521

## CERTIFICATE OF DEATH

Reg. Dist. No.

03408

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>107 Dawson Avenue, Apt. # 117</b>			
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Lee</b> Last <b>Benton</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1944</b>		9. AGE (in years last birthday) <b>16</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Maurice Benton</b>				14. MOTHER'S MAIDEN NAME <b>Edna Millison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Purulent tracheobronchitis</b> DUE TO (c) <b>Cystic Fibrosis of the Pancreas</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>6 years</b> <b>16 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from <b>February 15, 1960</b> to <b>March 14, 1960</b> that I last saw the deceased alive on <b>March 14, 1960</b> and that death occurred at <b>9:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edward L. Eyerman</b> M.D. <b>The Clinical Center</b> <b>3/14/60</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conneaut Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Conneaut, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 16 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kline</b>			

HOSPITAL

VS A15 (4)  
15M 9/58

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

CTOR: After this certificate has been signed by the attending physician and completed by the hospital, it should be filed with the funeral director.

n 24 hours after death. Page 4

3507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Paterson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paterson</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington GARDENS Nursing Home</u>				d. STREET ADDRESS <u>307 9th Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Reselyn</u> Middle <u>-</u> Last <u>BERMAN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>2-6</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15 1874</u>		9. AGE (in years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Pollock</u>				14. MOTHER'S MAIDEN NAME <u>Diana Hegner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		INFORMANT <u>Husband (Isidor)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Cerammatosis</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Biliary Carcinoma</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/11</u> , 19 <u>60</u> , to <u>3/26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>60</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max G. Storer</u> M.D.				DATE SIGNED <u>3/26/60</u>			
PHYSICIAN'S NAME (Type) <u>Max G. STORER MD</u>				ADDRESS (Street, city or town, state) <u>2025 East West A'way Silver Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH Va.</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dancusky &amp; Sons</u>				ADDRESS <u>3501-14 St. N.W.</u>		24a. REC'D BY REGISTRAR <u>MAR 29 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

page 3 should be attached to the certificate of death, and in any event within 72 hours after death.



3461

## CERTIFICATE OF DEATH

03410

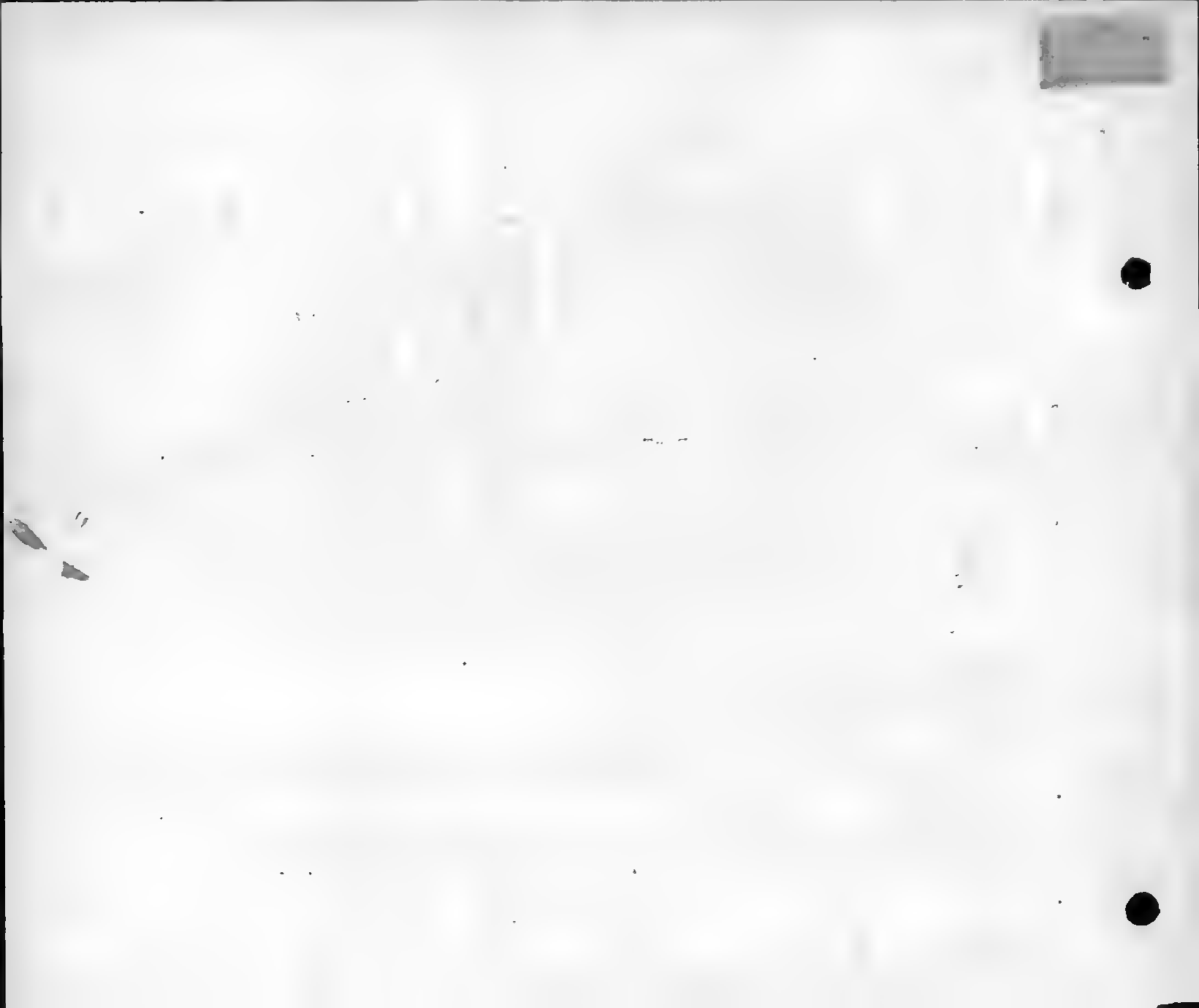
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>F. Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				d. STREET ADDRESS <u>1402 University Blvd.</u>			
3. NAME OF DECEASED (Type or print) <u>William Henry Black</u>				4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-23-88</u>	
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS: Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Black</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>579-01-9075-A</u>			
17. INFORMANT <u>Mr. Alonzo Black - Son</u>				Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myofasciitis C.V. disease</u> <u>443X</u> DUE TO <u>with annular fibulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO <u>Atherosclerosis, advanced</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma prostate</u> INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19</u> to <u>Feb 19</u> , 19 <u>60</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>1746 K Street N.W.</u> DATE SIGNED <u>Mar 2 1960</u>			
ACTUAL SIGNATURE <u>Irving Brotman</u> M.D.				PHYSICIAN'S NAME (Type) <u>IRVING BROTMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 23, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 8th Ave. S.S. Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

Dr. Frank J. Broschart, Deputy Med. Examiner, notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03411

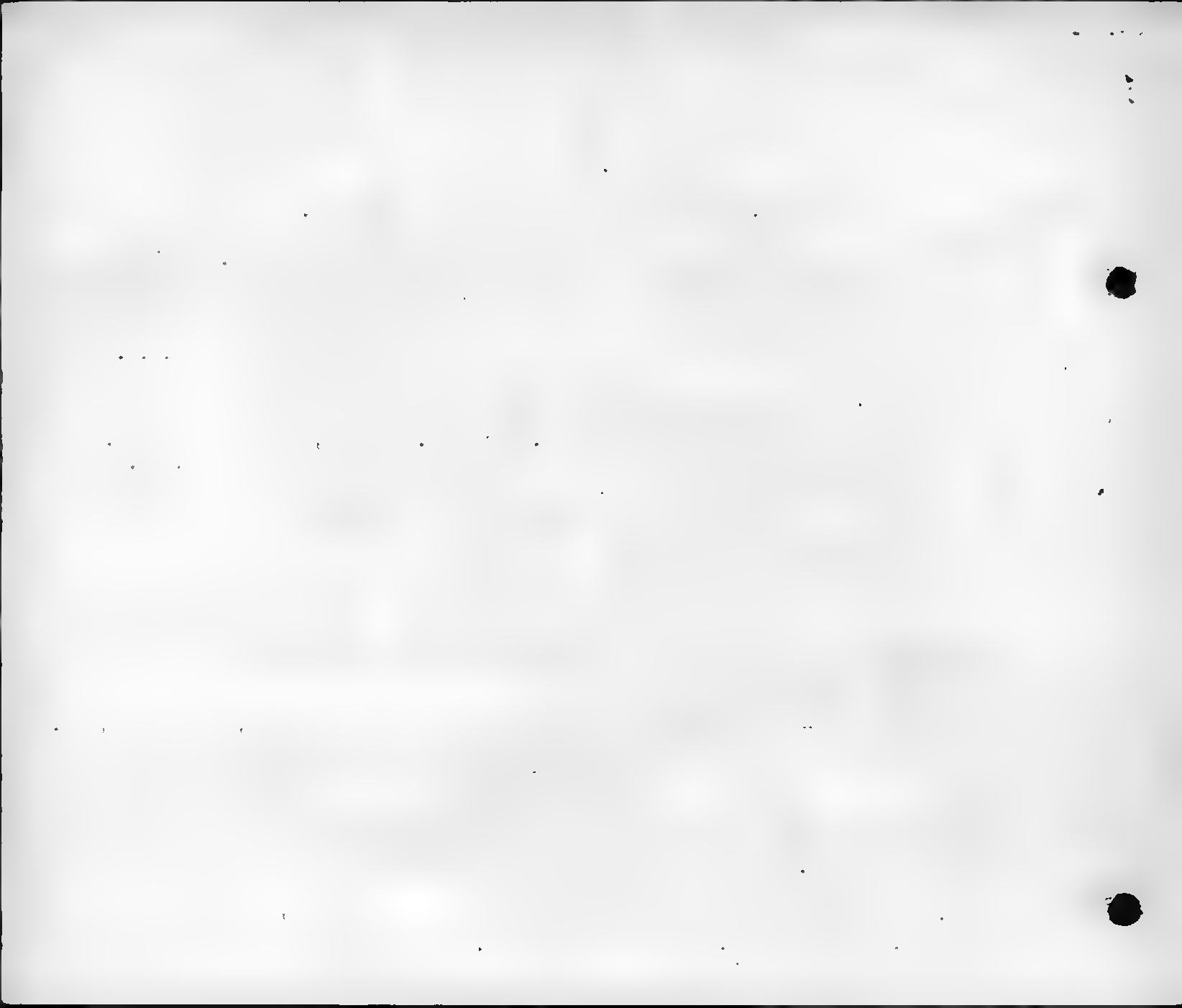
Reg. Dist. No.

3402

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

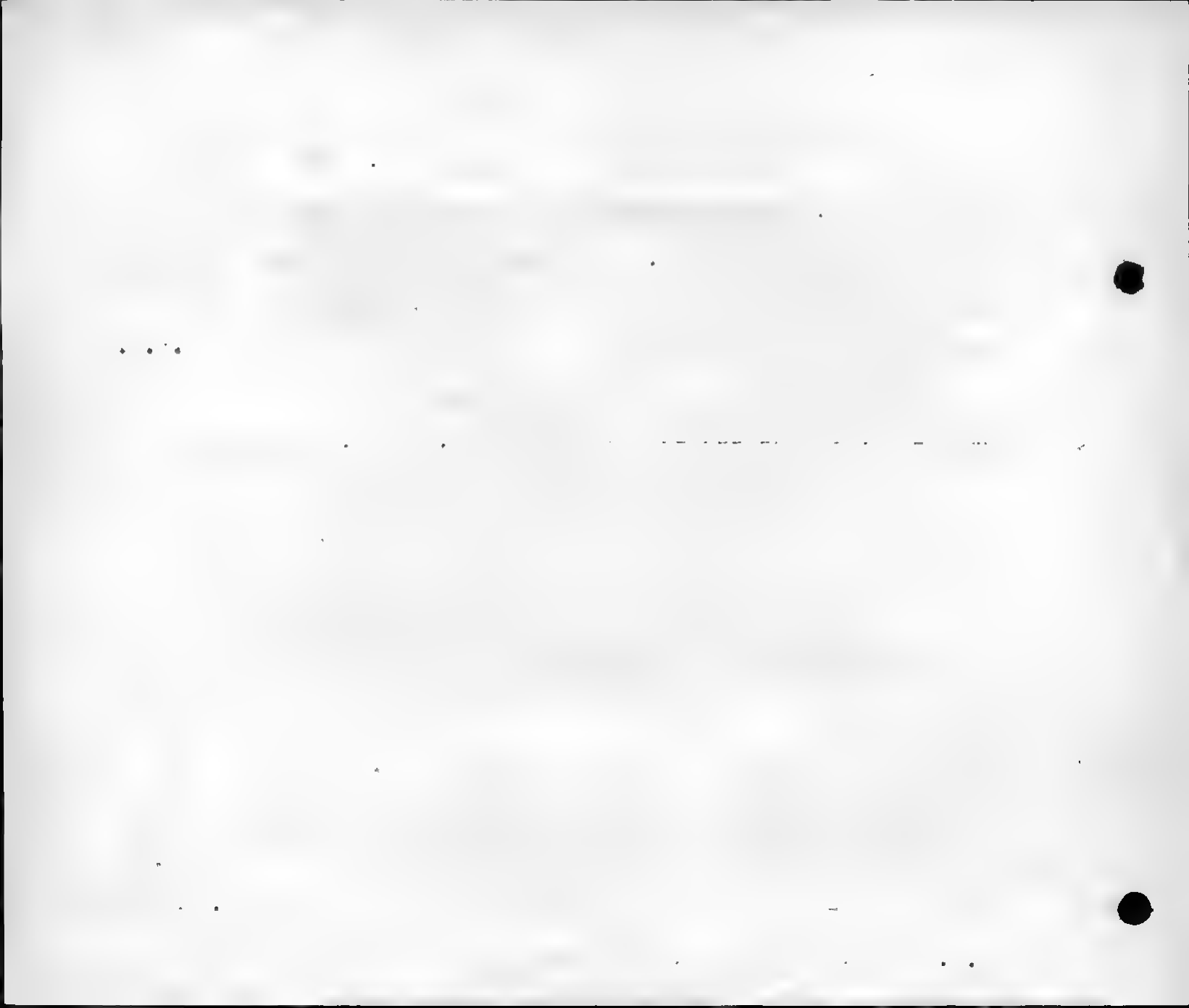
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>9 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>	
		f. STREET ADDRESS <b>8217 Roanoke Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES JASON BLEVINS</b>		4. DATE OF DEATH Month <b>MAR.</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/58</b>
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>23</b> Hours <b>9</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAROLD R. BLEVINS</b>		14. MOTHER'S MAIDEN NAME <b>GLADYS CLIFFORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>[If yes, give war or dates of service]</b>		16. SOCIAL SECURITY NO. <b>Mr. Harold R. Blevins, 8217 Roanoke Ave. Takoma Park, Md.</b>	
17. INFORMANT <b>Mr. Harold R. Blevins, 8217 Roanoke Ave. Takoma Park, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SHOCK</b> <b>917-3</b> DUE TO (b) <b>2nd &amp; 3rd degree burns involving about 1/3 of body</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9 hrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Pulled pan of boiling water from stove</b>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Pulled pan of boiling water from stove</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> <b>3-22-</b> <b>1960</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Takoma Park, Montgomery, Md.</b>		20g. (County) <b>Montgomery, Md.</b>	
20h. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/24/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MARIANNA, ARKANSAS</b>		22d. LOCATION (City, town, or county) (State) <b>MARIANNA, ARKANSAS</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Jiska</b>		24. REC'D BY REGISTRAR DATE <b>MAR 24 '60</b>	
25. REGISTRAR'S SIGNATURE <b>Richard E. Hume</b>		26. REGISTRAR'S SIGNATURE <b>Richard E. Hume</b>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 3522  
 CERTIFICATE OF DEATH

03412

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General Hospital</b>				d. STREET ADDRESS <b>Watersville Road</b>			
3. NAME OF DECEASED (Type or print) <b>KATIE M. BLOOM</b>				4. DATE OF DEATH <b>March 30 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1904</b>	
9. AGE (in years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Green</b>				14. MOTHER'S MAIDEN NAME <b>Emma Hatfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----			
17. INFORMANT <b>Calvin L. Bloom,</b>				Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Adenocarcinoma - metastatic</b> <b>170X</b> DUE TO <b>Primary Adenocarcinoma Left Breast</b> <b>(Radical Breast Amputation Oct. 25, 1958)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1, 1949</b> , to <b>March 30, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1960</b> , and that death occurred at <b>1:15 a. m.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> M.D.				22b. DATE <b>3/30/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D.</b>				22d. ADDRESS <b>9830 Main Street Damascus, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-2-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz,</b>				25a. REC'D BY REGISTRAR <b>Winfield, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				25c. DATE <b>APR 4 '60</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03413

3523

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KENSINGTON</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>				d. STREET ADDRESS <b>3508 Murdock Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ivory</b> Middle <b>Dennis</b> Last <b>Bowen</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1953</b>		9. AGE (In years last birthday) <b>6</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul H. Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Betty Jo Wells</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Father - Paul H. Bowen</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Suffocation</b> DUE TO <b>Foreign body in larynx (chewing gum)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>minutes</b> DUE TO <b>minutes</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tracheobronchitis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Aspirated chewing gum while coughing</b>					
20c. TIME OF INJURY Month, Day, Year <b>9 a.m. March 8 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Kensington</b> (County) <b>Montgomery</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate City</b>		22d. LOCATION (City, town, or county) <b>Gate City</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>N. Don. Vol. 2224-Wis. Am. Co.</b>				ADDRESS <b>2224 Wisconsin Ave. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thack</b>			

3-9-60

Gate City



1. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corba papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

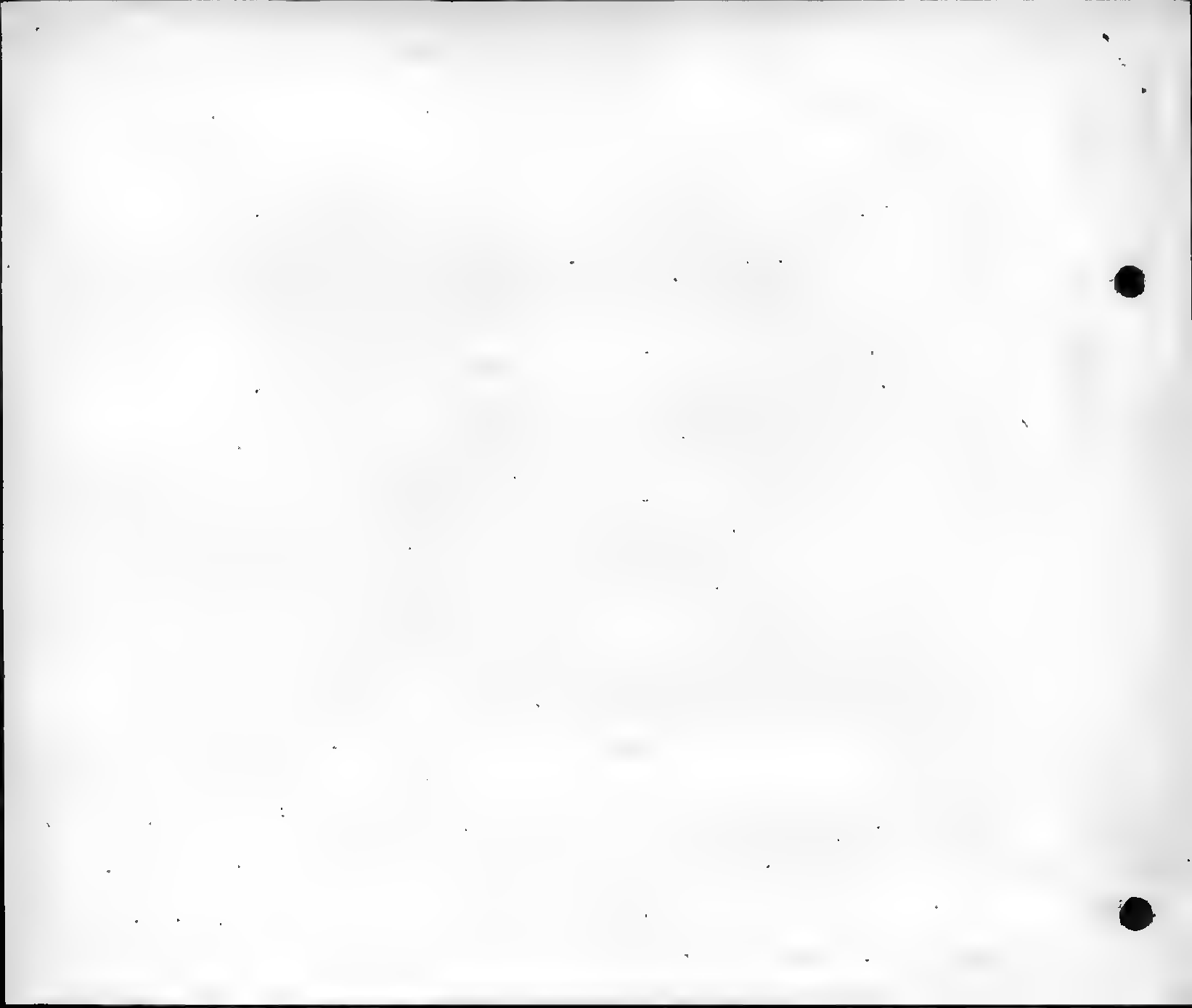
3524

## CERTIFICATE OF DEATH

Reg. Dist. No.

03414

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X</u> Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ressie</u> Middle <u>G.</u> Last <u>Britton</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/02</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STUART GARBER</u>		14. MOTHER'S MAIDEN NAME <u>SALLY MACCL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>HUSBAND - SAME as Above</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>172X Congestive Heart Failure</u> DUE TO (b) <u>Mitotic Carcinoma Lung Liver Spine</u> DUE TO (c) <u>Carcinoma Right Breast</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause ast.		INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>5 YRS</u> <u>10 1/2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 16</u> , 19 <u>53</u> , to <u>MAR 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAR 4</u> , 19 <u>60</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		<u>5009 DelRay Ave. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	





3525

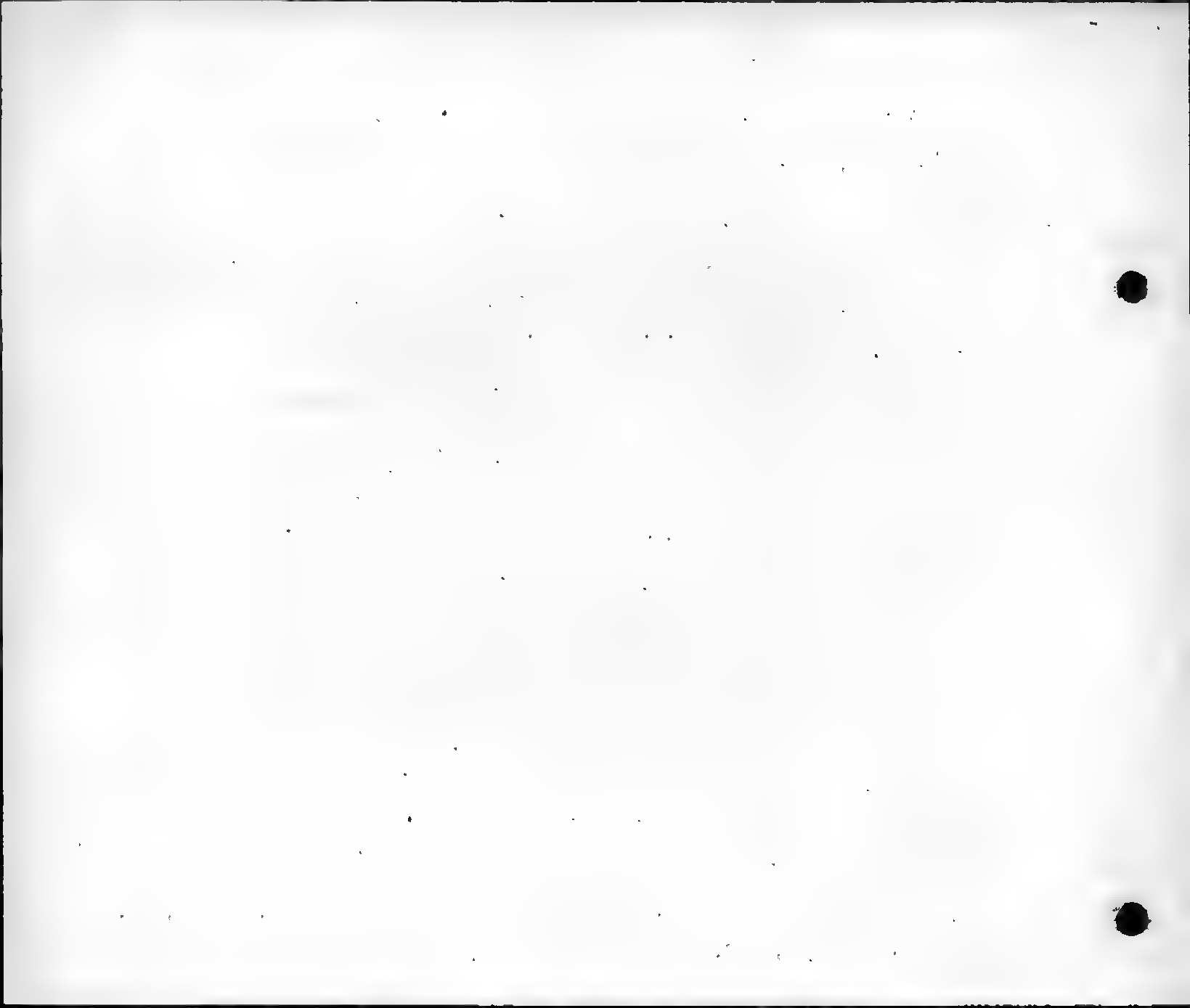
## CERTIFICATE OF DEATH

03415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
f. STREET ADDRESS <u>1818 First Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Mabel Brower</u>		4. DATE OF DEATH Month Day Year <u>March 20 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28 1893</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> CLERK		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. WAR DEPT.</u> Own home	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter S. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Margaret B. Lucy Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO (b) <u>Coronary Thrombosis (prev. 1.19)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>12 hours</u> <u>3 1/2 hrs.</u> <u>?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 21, 1956</u> to <u>Mar. 20, 1960</u> that I last saw the deceased alive on <u>Mar. 20, 1960</u> and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irwin I. Yager</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3055-16th St. N.W. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>IRWIN I. YAGER</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Zick</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knepp</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2  
VS A15 (4)  
15M 9/58



1

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon bands from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3512

CERTIFICATE OF DEATH

Reg. Dist. No.

03416

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 N. Adams Street</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b> d. STREET ADDRESS <b>101 N. Adams Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH ENGLAND BROWN</b> First Middle Last				4. DATE OF DEATH <b>March 20, 1960</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 25, 1875</b>	
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Trew England</b>				14. MOTHER'S MAIDEN NAME <b>Annie Griffith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>W. Maynard Brown</b>				Address <b>48 Colonial Ridge Dr. Haddonfield, N. J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombus</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>20 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 25, 1952</b> to <b>26 March 1960</b> that I last saw the deceased alive on <b>26 March 1960</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3/26/60</b> ACTUAL SIGNATURE <b>W.S. Murphy</b> M.D. PHYSICIAN'S NAME (Type) <b>W.S. Murphy</b> <b>615 W. Montgomery Ave., Rockville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>1331 E. Montg. Ave. Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

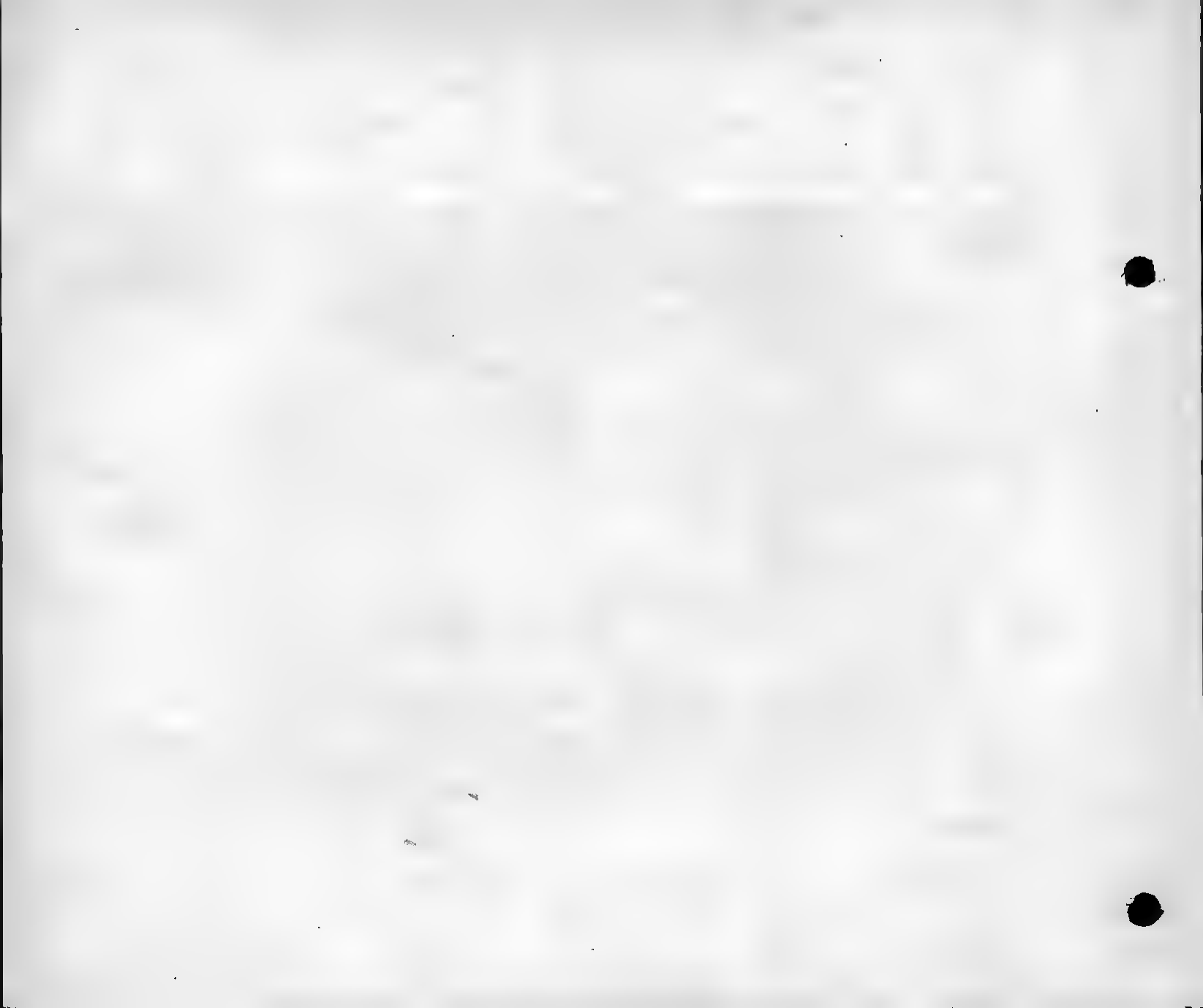
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03417

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and (town)) <u>Takoma Park, D.C.</u> c. LENGTH OF STAY IN 1b <u>D.C.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> d. STREET ADDRESS <u>404 Montrose Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilmer Martin Burch</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>27</u> Year <u>1960</u>		<b>5. SEX</b> <u>Male</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-30-03</u>			
<b>9. AGE</b> (In years last birthday) <u>56</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>27</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>1</u> Min. <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SERVICE - U.S. ARMY</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ARMED FORCES</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Waldorf Md.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>							
<b>13. FATHER'S NAME</b> <u>JESSIE BURCH</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II - KOREA</u>		<b>16. SOCIAL SECURITY NO.</b> <u>W.W.II - KOREA</u>		<b>17. INFORMANT</b> <u>Virginia M. Burch</u> Address <u>939 Bonifant St. S.S.Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LACERATION AND RUPTURE OF HEART DUE TO CRUSHED CHEST</u> DUE TO <u>16x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>minutes</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>CONTRIBUTING</b> <input checked="" type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car involved in 2 car accident - struck by 3rd car</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>2</u> a.m. <u>3-27</u> 1960		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Hd. R - 29206 Rd.</u>			
<b>20f. (City or town)</b> <u>Howard</u>		<b>20g. (County)</b> <u>MD</u>		<b>20h. (State)</b> <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Blaszczak</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>3-27-60</u>			
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BLASZCZAK</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>March 30, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Virginia</u>		<b>22e. (State)</b> <u>VA</u>		<b>22f. ADDRESS</b> <u>254 Carroll St. N.W.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			
<b>DATE</b> <u>MAR 30 '60</u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03418

3526

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b> <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>30 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ijamsville</b>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Mc Sherry</b> Last <b>Burgee</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/21/03</b>		9. AGE (In years last birthday) <b>57</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Mc Sherry Burgee</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Day</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-7627</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Vascular - Renal Disease</b> <b>44 x</b> DUE TO <b>① Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <b>② Renal Disease and hypertension</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>③ Diabetes Mellitus ④ Parkinson's Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>5 years</b> <b>3 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1950</b> to <b>March 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1960</b> , and that death occurred at <b>10:29</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>M. McKendree Boyer</b>				22b. DATE SIGNED <b>3/6/60</b>		22c. PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer</b>	
22d. ADDRESS <b>9830 MAIN ST Ijamsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3523 Item 4, File 8-23, 1/21/60, etc.

3523

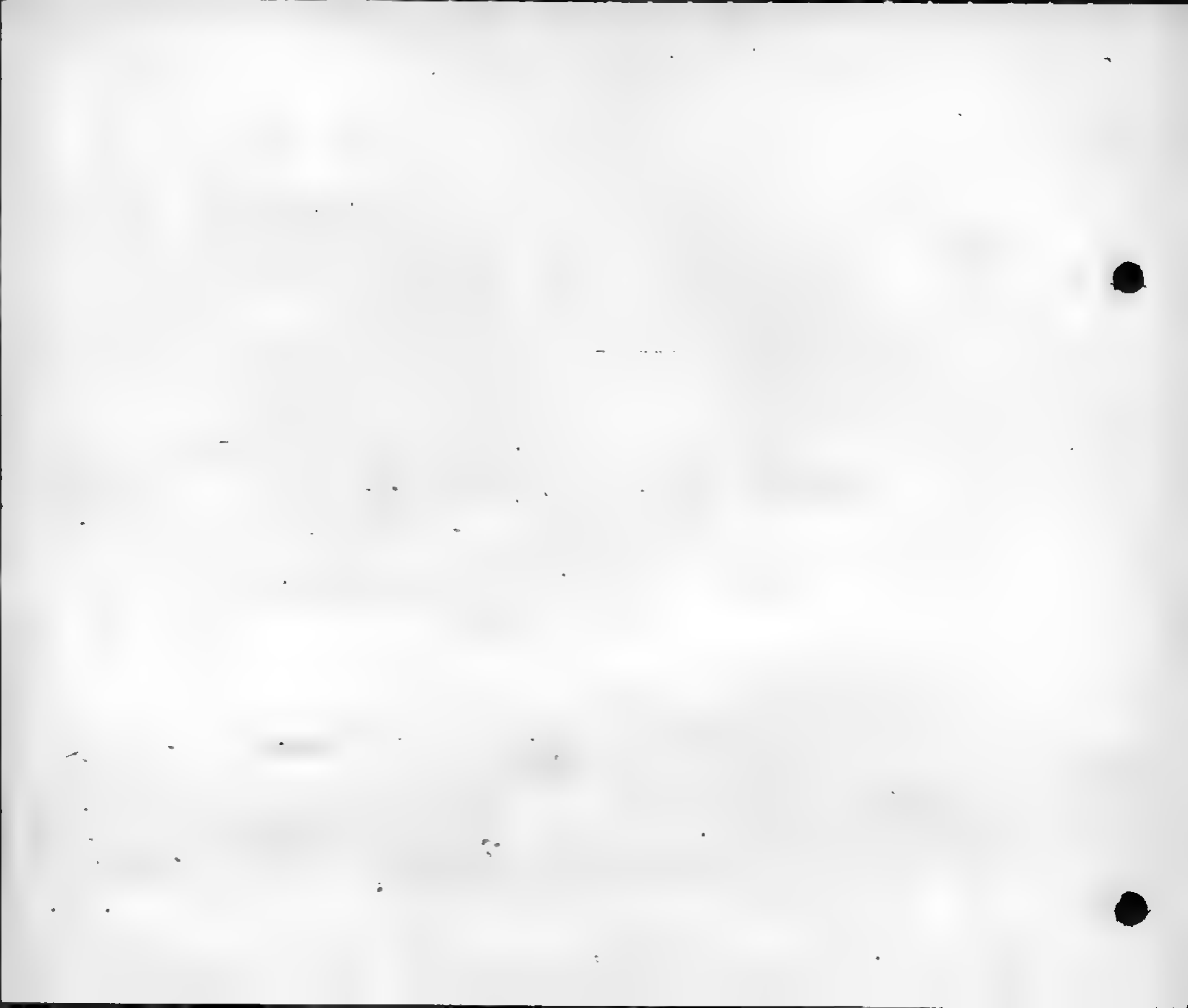
Item 4, File 8-23, 1/21/60, etc.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03419

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5015 Del Ray Avenue</b>				e. STREET ADDRESS <b>5015 Del Ray Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nell F Butler</b>				4. DATE OF DEATH Month Day Year <b>March 13 12 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/6/1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>		11. IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S</b>							
13. FATHER'S NAME <b>Charles Forsdick</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs. Cunningham-daughter-same as 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>Arteriosclerotic Heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 day</b> <b>1/2 day</b> <b>2 1/2 yr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour a m p m <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b></b>	
20f. (City or town) <b></b> (County) <b></b> (State) <b></b>							
21. I certify that (I) (this hospital) attended the deceased from <b>July 1 59</b> to <b>Mar. 12 1960</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Robert A. Pumphrey</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12 Mar 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT A. RICHWINE, M.D.</b>				22d. ADDRESS <b>5322 WILSON AVE, CHEVY CHASE, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/15/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) <b>Prince George Co. Md.</b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 16 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	



**3522**

**CERTIFICATE OF DEATH**

Reg. Dist. No.

**03420**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> c. LENGTH OF STAY IN 1b <u>4</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2521 Grosvenor Lane Sanit.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2521 Grosvenor Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mabel Frank Butterfield</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>3 5 1960</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-27-1870</u>	
<b>9. AGE</b> (In years last birthday) yrs. <u>89</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>12. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>	
<b>13. BIRTHPLACE</b> (State or foreign country) <u>Illinois</u>		<b>14. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. FATHER'S NAME</b> <u>THOMPSON</u>		<b>16. MOTHER'S MAIDEN NAME</b> <u>Franklin</u>	
<b>17. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>18. SOCIAL SECURITY NO.</b> <u>no</u>	
<b>19. INFORMANT'S NAME</b> <u>Willa Nestcott</u>		<b>20. ADDRESS</b> <u>2725-29th St NW Washington, DC</u>	
<b>21. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>? Bronchopneumonia</u> (b) <u>Generalized arteriosclerosis</u> (c) <u>Fracture of femur, recent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femur, recent</u>			
<b>22. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4</u>			
<b>23. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>24b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>25a. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>25b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>26a. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>26b. (City or town)</b> (County) (State)	
<b>27. I certify that I attended the deceased from</b> <u>1957</u> to <u>5 Mar, 1960</u> , that I last saw the deceased alive on <u>29 Feb</u> , 19 <u>60</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
<b>28. ACTUAL SIGNATURE</b> <u>Robert T. Kelley</u>		<b>29. ADDRESS</b> (Street, city or town, state) <u>3132-16 St. NW, DC</u>	
<b>30. PHYSICIAN'S NAME</b> (Type) <u>Robert T. Kelley</u>		<b>31. DATE SIGNED</b> <u>3/6/1960</u>	
<b>32a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>32b. DATE THEREOF</b> <u>3/6/1960</u>	
<b>33a. NAME OF CEMETERY OR CREMATORY</b> <u>Windsor, Ohio</u>		<b>33b. LOCATION</b> (City, town, or county) (State)	
<b>34. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S. M. Hines Co.</u>		<b>35. ADDRESS</b> <u>2901-14th St NW-DC</u>	
<b>36a. REC'D BY REGISTRAR</b> DATE <u>MAR 8 '60</u>		<b>36b. REGISTRAR'S SIGNATURE</b> <u>Conrad S. Finner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3529

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

C3421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>5244 44th St N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kennedy &amp; Deane Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Warren Franklin Byrd</u>				4. DATE OF DEATH Month Day Year <u>March 3 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-91</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>very chief-CPO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Byrd</u>				14. MOTHER'S MAIDEN NAME <u>Sally Sterling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>578-30-5198</u>		17. INFORMANT <u>Robt Byrd (son)</u>		Address <u>2009 N. Daniel St Arlington, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>420.1</u> DUE TO (b) <u>Myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Coronary insufficiency</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed myocardial infarction</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3-4-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>3-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Methodist Church Cem.,</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3530

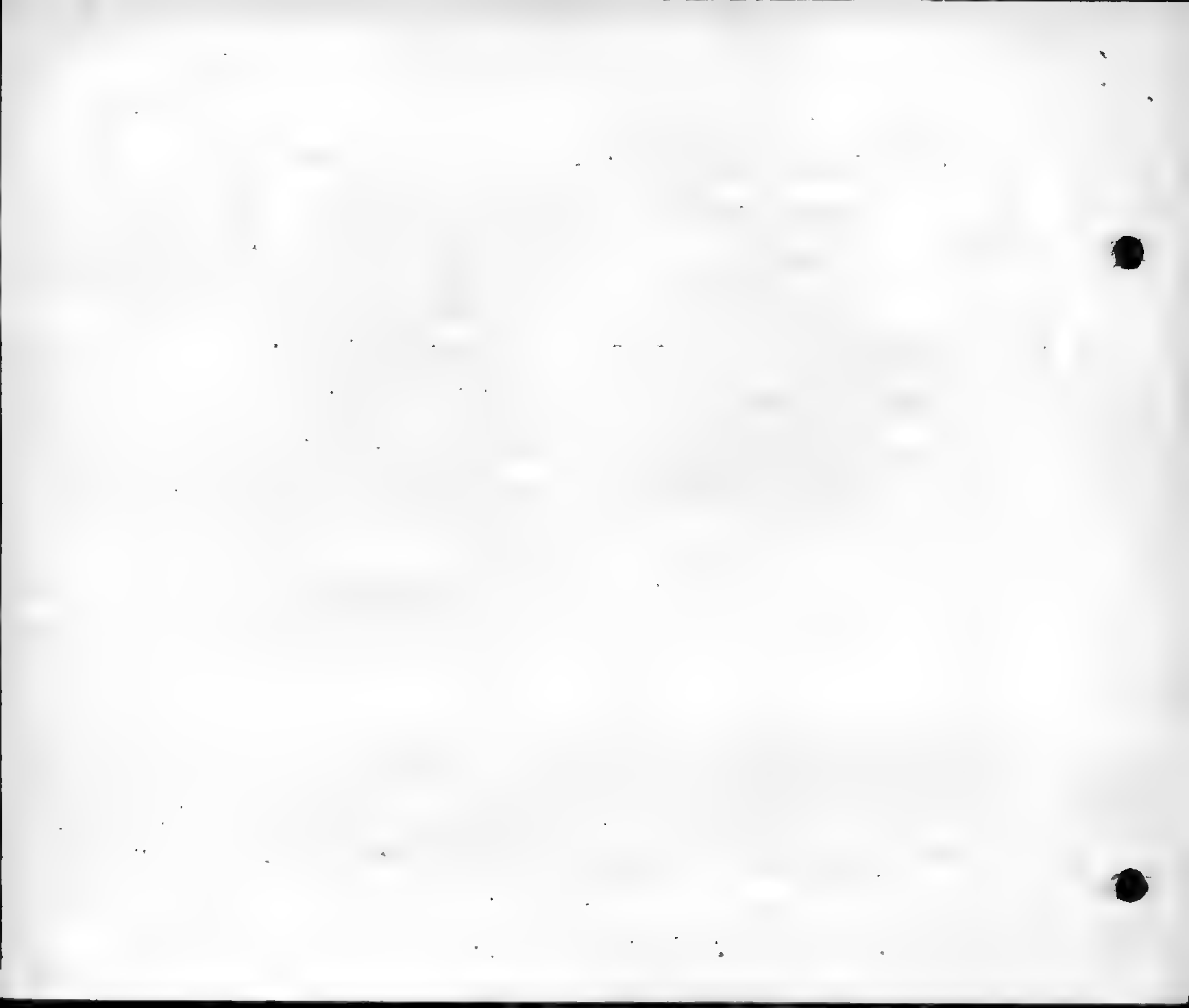
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>68 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M</b> Last <b>Byrne</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/14</b>
9. AGE (In years last birthday) <b>45 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
11. BIRTHPLACE (State or foreign country) <b>Berryville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thadeus Montague Whiting</b>		14. MOTHER'S MAIDEN NAME <b>Lelila Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Wac Army Unknown</b>	
17. INFORMANT <b>Husband John J. Byrne (Same as above)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b> <b>Acute myocardial infarction, R. ventricular, 6 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Due to</b> (c) <b>Due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 6 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 5, 1952</b> to <b>March 7, 1960</b> , that I last saw the deceased alive on <b>March 7, 1960</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>P. P. Tabb, M.D.</b>		22b. ADDRESS (Street, city or town, state) <b>1300 Georgia Ave. Silver Spring</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 10 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



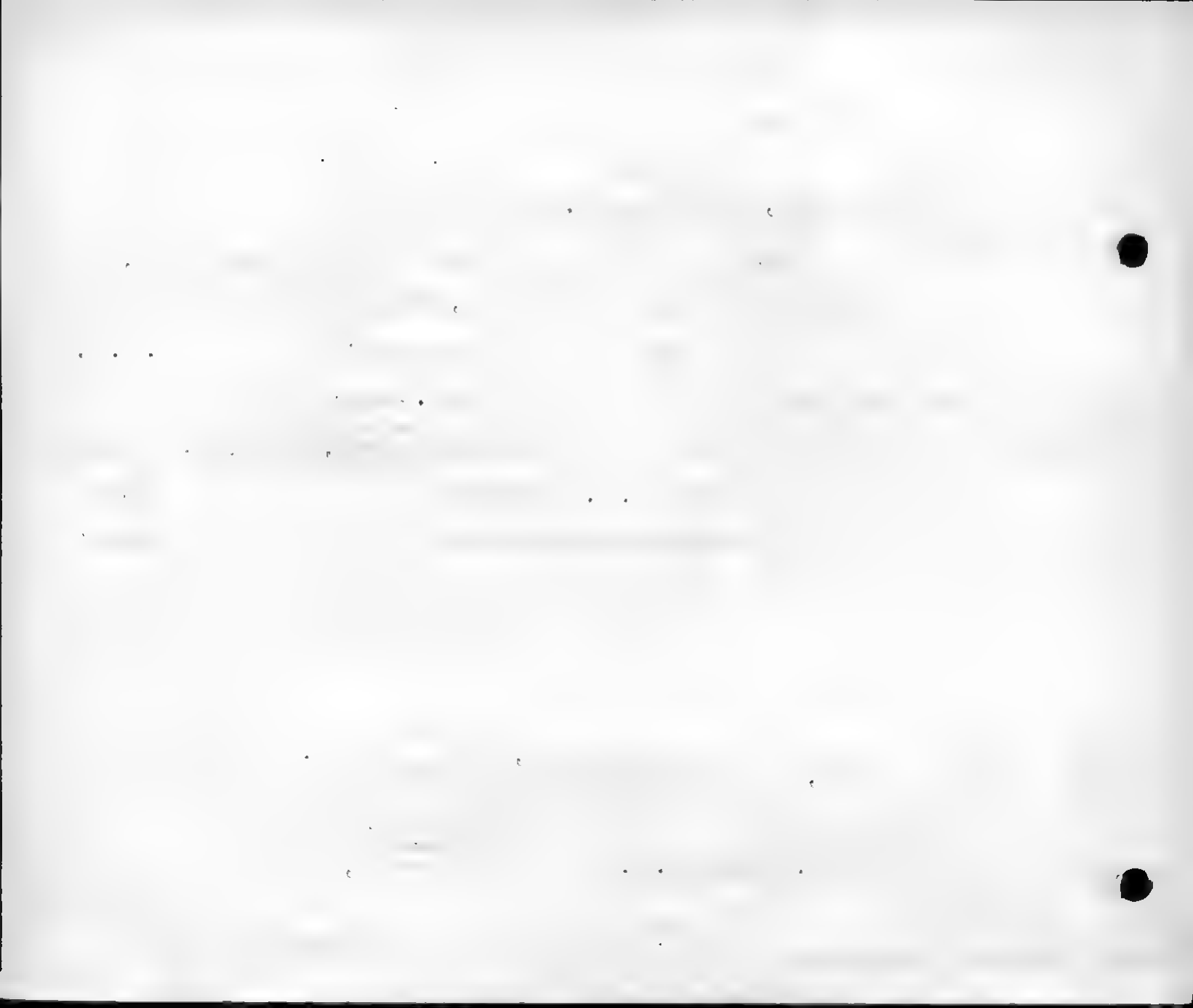


3531

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) o. STATE <b>West Virginia</b> b. COUNTY <b>West Virginia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>67 days</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clayton</b> Middle <b>Jay</b> Last <b>Byus</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5, 1950</b>	
9. AGE (In years last birthday) <b>9 yrs</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>15</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Jerry Robert Byus</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Jacobs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive G. I. hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 8, 1960</b> to <b>March 15, 1960</b> that I last saw the deceased alive on <b>March 15, 1960</b> and that death occurred at <b>5:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/15/60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Arthur R. Rothman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>ARTHUR R. ROTHMAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>SHIP RR.</b>		<b>3-16-1960</b>		<b>Point Pleasant West Va.</b>		<b>West Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Chambers 1400 Chapin St NW</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

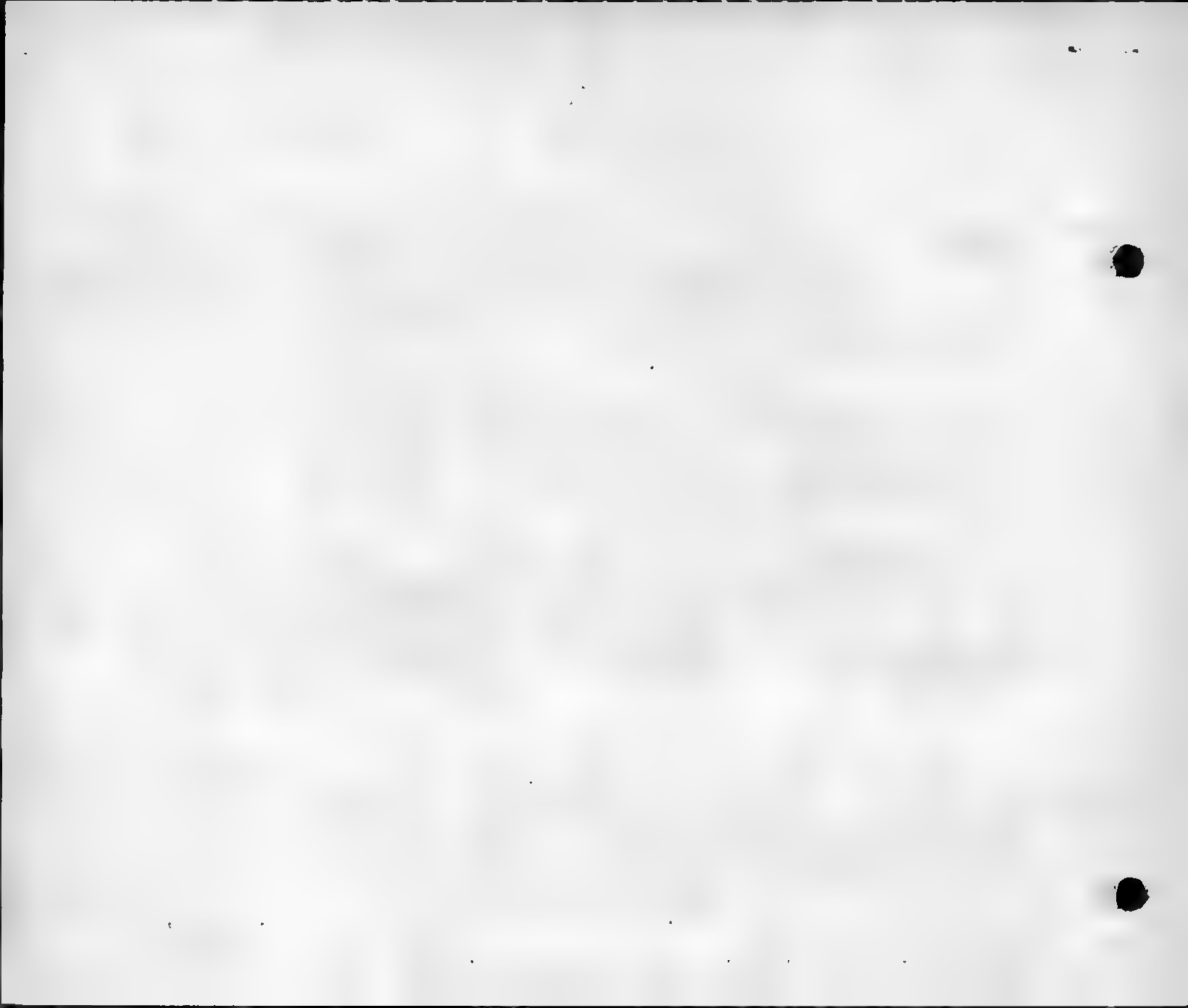
## 3466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03424

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> <span style="float: right;">4743</span> d. STREET ADDRESS <u>7421 Blair Rd NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Paul Herbert Camp</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>1</u> Year <u>1960</u>			
<b>5. SEX</b> <u>m</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-10-95</u> <b>9. AGE</b> (In years last birthday) <u>64</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during the preceding year if retired) <u>REPRESENTATIVE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FISHER SCIENTIFIC LAB.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Hubert T. Camp</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Dixon Dixon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>yes WWI</u>				<b>16. SOCIAL SECURITY NO.</b> <u>yes</u>		<b>17. INFORMANT</b> <u>Mrs Elizabeth C. Camp</u> Address _____	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____ <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCANT</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>3-1-60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u>		<b>22b. DATE THEREOF</b> <u>3/3/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>FT. LINCOLN CREMATORY</u>		<b>22d. LOCATION</b> (City, town, or county) <u>PRINCE GEO. COUNTY, MARYLAND</u> (State) _____	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond E. Ziska</u>				<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>MAR 3 '60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Thompson</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in the files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3532

## CERTIFICATE OF DEATH

Reg. Dist. No.

03425

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Emma Rebecca</u> First Middle Last <u>Carlin</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Boyd's Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			

13. FATHER'S NAME <u>Wm Edgar Larman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rebecca Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Miss Frances R. Carlin</u>	
17. ADDRESS <u>2800 Quebec St Wash. D.C.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Atypical</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Pulmonary Fibrosis &amp; Emphysema</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cor Pulmonale</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>July 20, 1951</u> , to <u>March 16, 1960</u> , that I last saw the deceased alive on <u>15 March, 1960</u> , and that death occurred at <u>8:53 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Gordon M. Smith</u>	DATE SIGNED <u>16 March 60</u>
PHYSICIAN'S NAME (Type) <u>Barnesville, Md.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>3/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Barnesville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 1960</u>	24b. REGISTRAR'S SIGNATURE <u>William B. Hillen</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 9, Film G25, 3/16/60

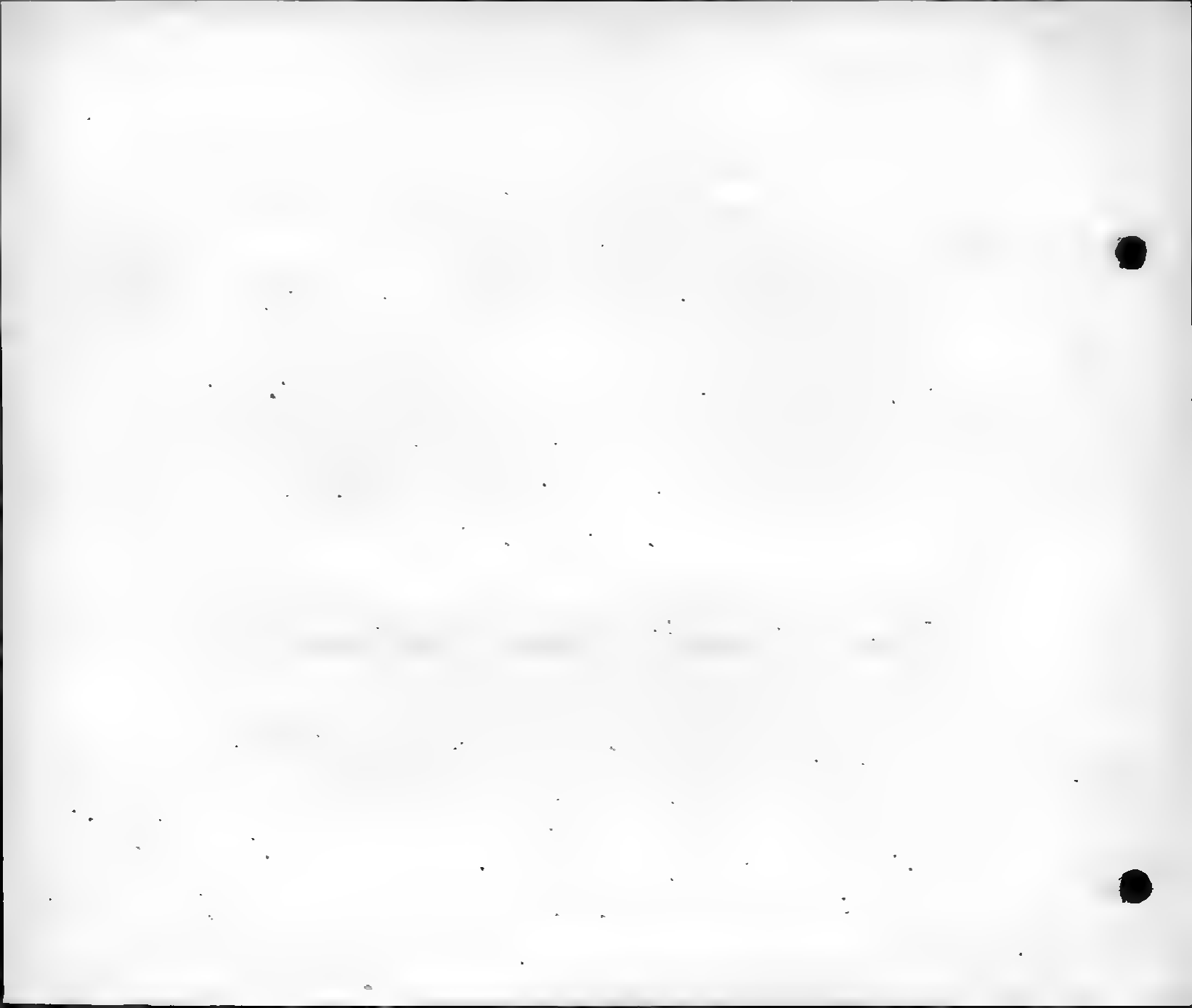
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>19100 Old Georgetown Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M</u> Last <u>CHARTER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWF</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARDEN CARTER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE V. FLEENOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>12609</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>59</u> to <u>March 4, 1960</u> that I last saw the deceased alive on <u>Feb 29</u> 19 <u>60</u> , and that death occurred at <u>1:21</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>		ADDRESS (Street, city or town, state) <u>4890 Beechery Lane, Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>		DATE SIGNED <u>3/4/60</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u>		ADDRESS <u>3605-14 St NW</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

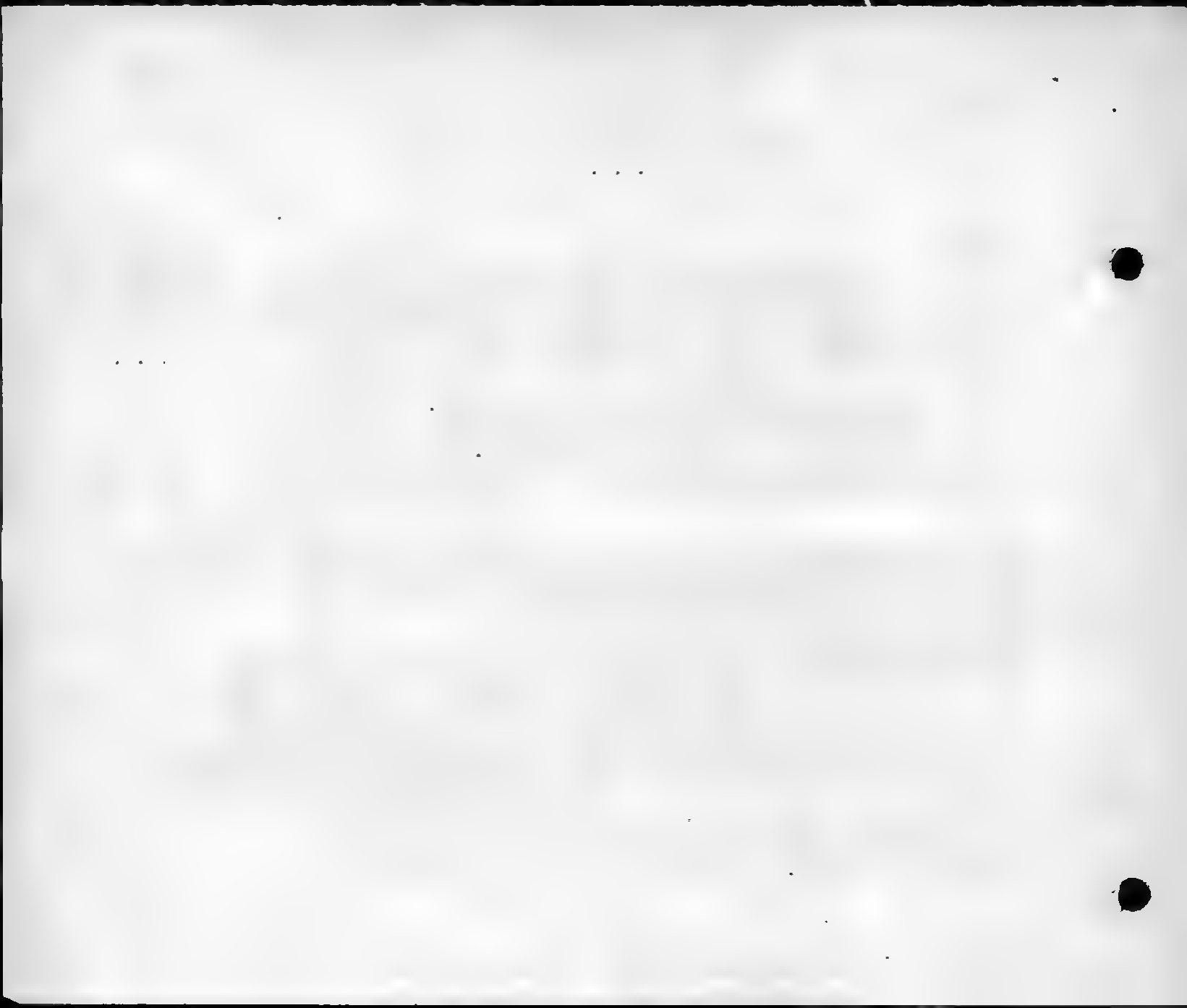
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03427

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>9412 Locust Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Horace</u> Last <u>Chadwick</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Chadwick</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes-Unknown</u>		17. INFORMANT <u>Marie E. Chadwick - same - wife</u> Address <u>2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3/17/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Knecht</u>			

**PROPERTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3465

## CERTIFICATE OF DEATH

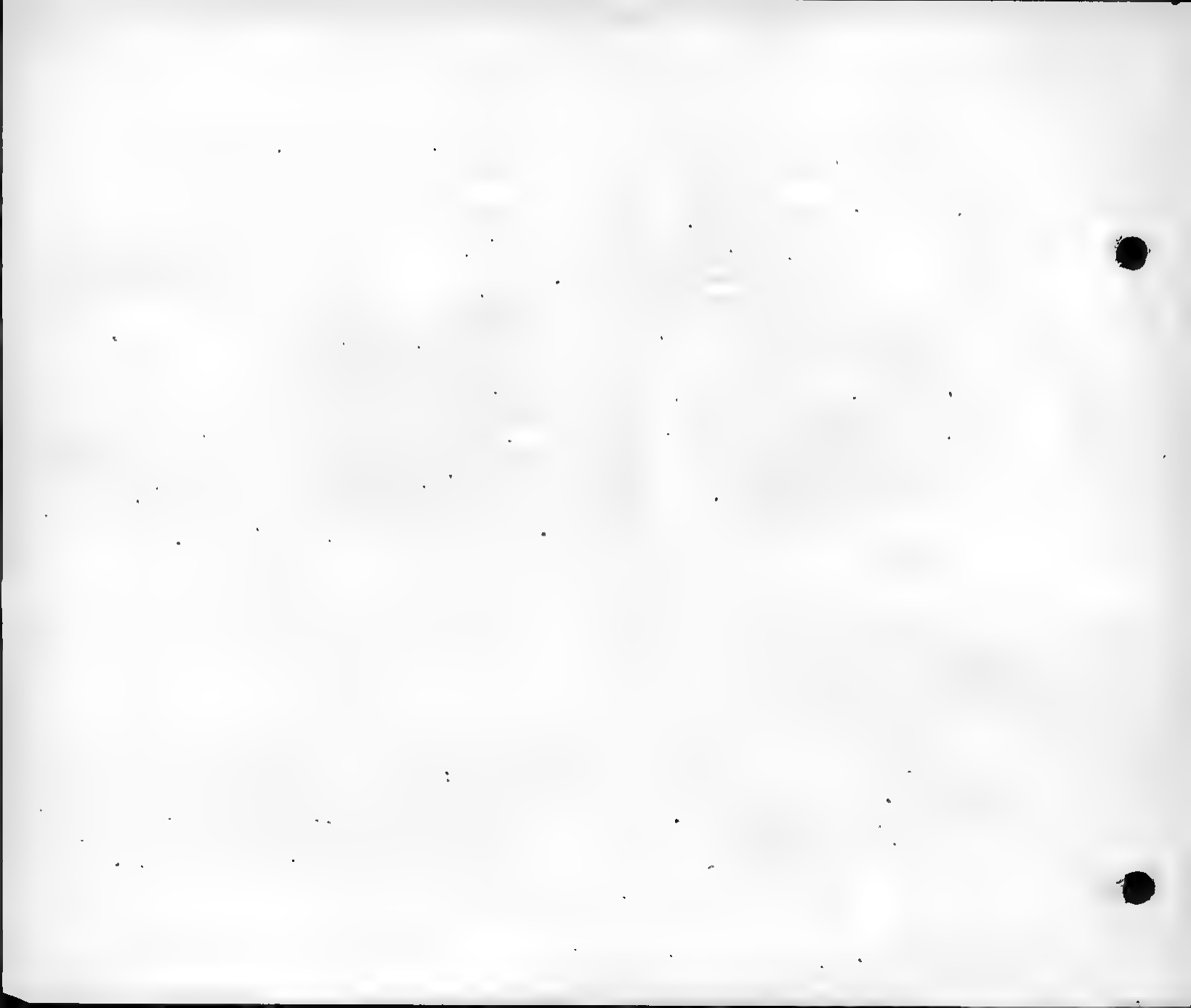
Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN Tn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San &amp; Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Evelyn</i> Middle <i>Marie</i> Last <i>Chilson</i>				4. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1960</i>			
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>Ca</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/18/54</i>	9. AGE (In years lost birthday) <i>5</i> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Takoma Park, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ernest H. Chilson</i>				14. MOTHER'S MAIDEN NAME <i>Helen A. Anderson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT Address <i>Hosp. Records. W.S.H.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>492X Interstitial Pneumonia (Virus)</i> DUE TO <i>Generalized Lymphadenopathy (Virus)</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Lymphadenopathy (Virus)</i> DUE TO <i>hours</i> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mongolism</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 11, 1958</i> to <i>March 18, 1960</i> , that I last saw the deceased alive on <i>Dec 5, 1958</i> , and that death occurred at <i>3:00 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip E. Jones</i>		M.D. <i>918 Ellsworth Drive</i>		DATE SIGNED <i>3/18/60</i>			
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 22, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ardenwood Memorial Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wilmington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters - 254 Carroll St. N.W.</i>				24. REC'D BY REGISTRAR DATE <i>MAR 22 '60</i>		25. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



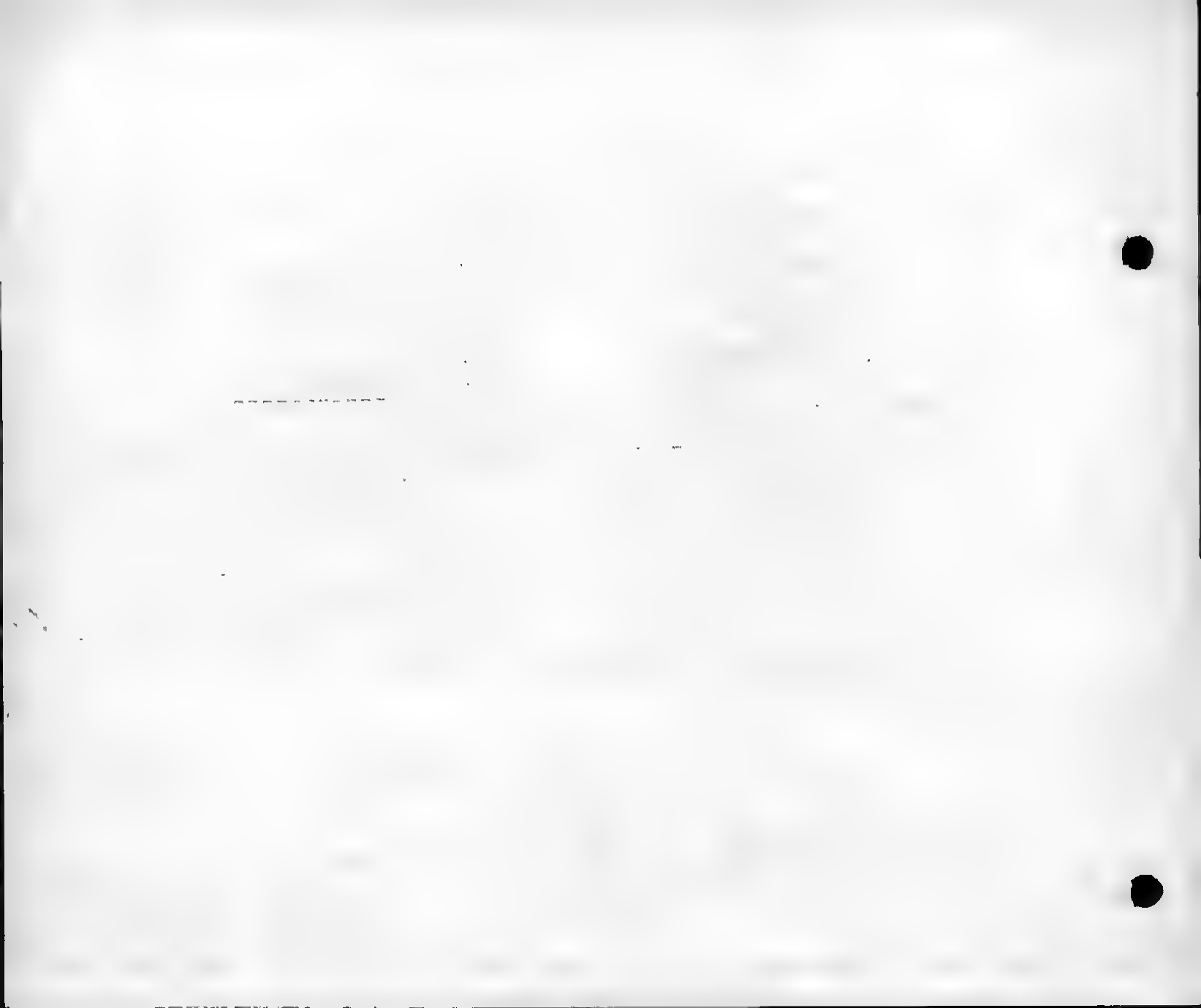
3466

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>		d. STREET ADDRESS <u>12203 Grandview Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Angelo Chipouras</u>		4. DATE OF DEATH Month Day Year <u>3 - 29 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-16</u>
9. AGE (In years lost birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Angelo Chipouras</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Ziavras</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Army WW2</u>		16. SOCIAL SECURITY NO <u>578-07-3328</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>432.1</u> DUE TO <u>HYPERTENSIVE &amp; ARTERIOSCLEROTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEART DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA</u>		19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> 19 <u>59</u> to <u>3/29</u> 19 <u>60</u> that I last saw the deceased alive on <u>3/28</u> 19 <u>60</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6727 16th St WASHINGTON, D.C.</u>	
ACTUAL SIGNATURE <u>David Goldenberg</u> M.D.		DATE SIGNED <u>3/29/60</u>	
PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>		<u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901-14 St. N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

3535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03430

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Meridian</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>15 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Meridian</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>1 Bartonville</u>	
3. NAME OF DECEASED (Type or print) <u>James Chrobot</u>		4. DATE OF DEATH <u>March 25 19 60</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Const.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence Chrobot</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-1348</u>	
17. INFORMANT <u>Label Chrobot, (wife)</u>		Address <u>Bartonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1</u> <u>hr</u> <u>1</u> <u>days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19 60</u> Hour a.m. <u>1</u> p.m. <u>1</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

2





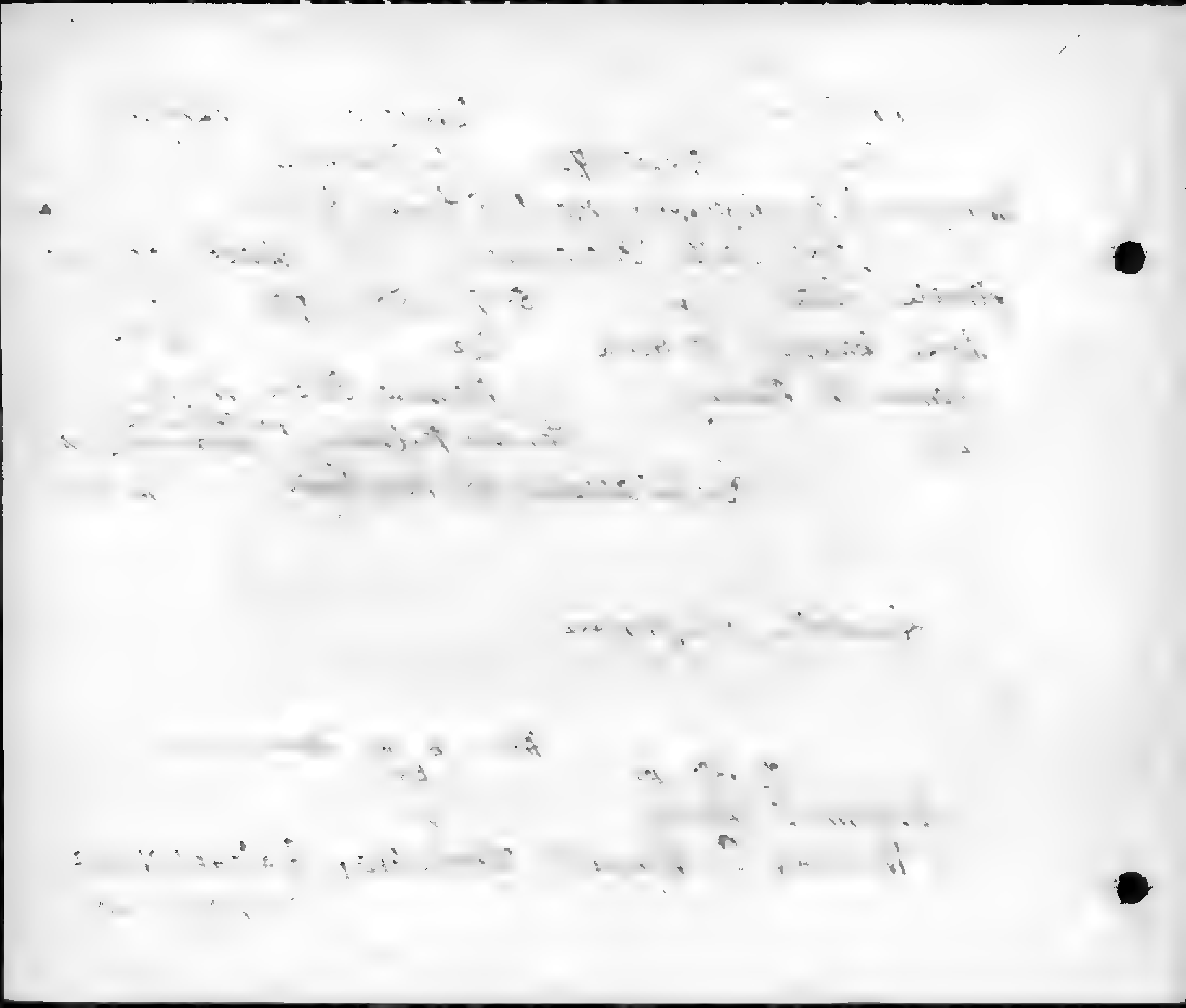
TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 48 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
15M 9/59

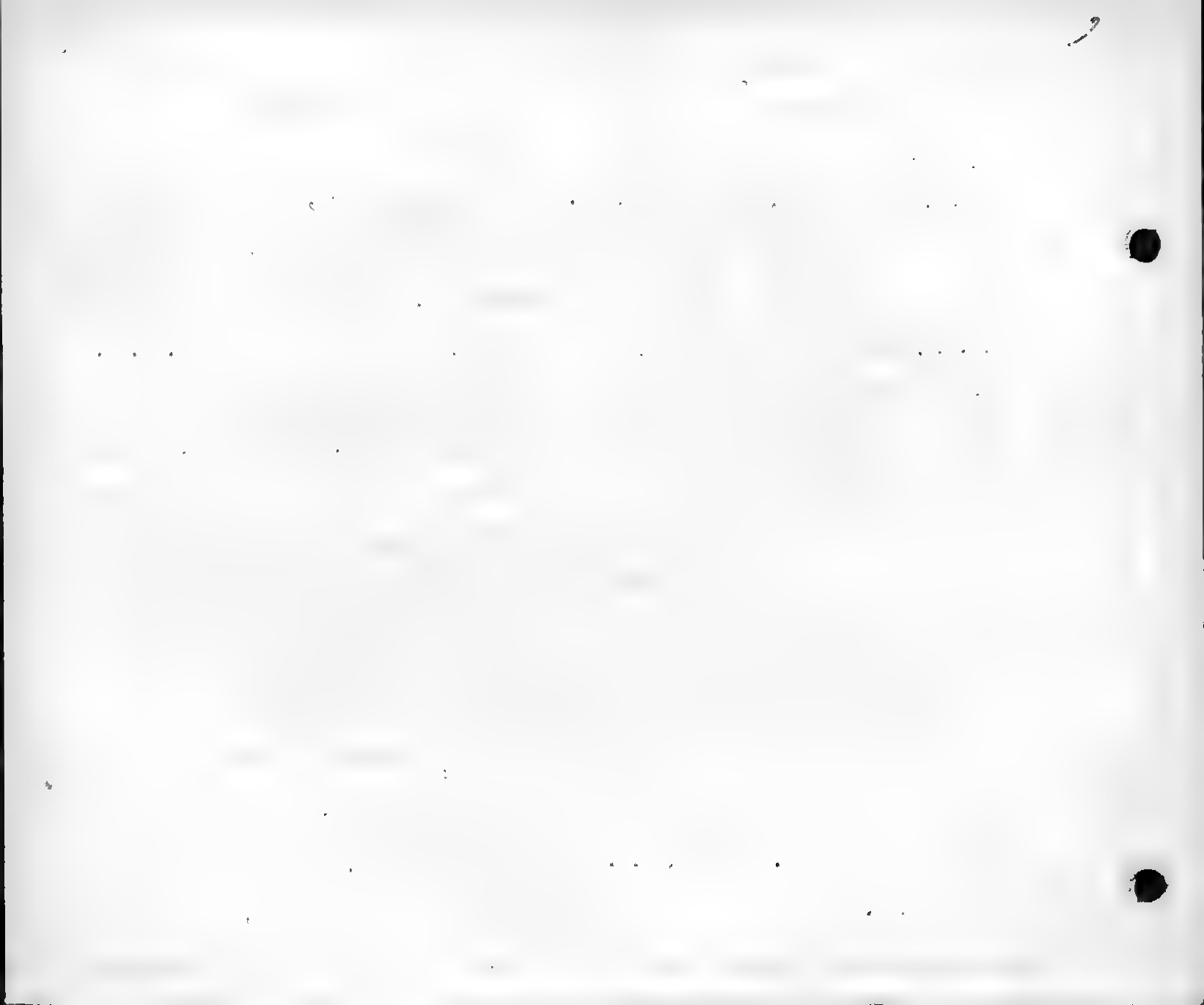
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3536  
CERTIFICATE OF DEATH

03431

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Only</u>		c. LENGTH OF STAY IN 1b <u>3/16/60 to 3/27/60</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthtersburg</u>		d. STREET ADDRESS <u>108 Filial Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. Gen. Hlth. Cntr., Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose Carter Claggett</u>		4. DATE OF DEATH <u>March - 27 - 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1880</u>
9. AGE (In years last birthday) <u>79</u> yrs	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	12. COUNTRY OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house - keeping</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James W. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Hells</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Lawrence B. Bailey, 108 Filial Dr., Gaithersburg, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral accident, (left hemiplegia)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u>	
DUE TO (b)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, Atherosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb - 16, 1960</u> to <u>March 27, 1960</u> , that (I) (we) last saw the deceased alive on <u>3-27-1960</u> , and that death occurred at <u>6:30 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Miller</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		22d. ADDRESS <u>1 BROOKS AVE., GAITHERSBURG</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Joshua</u>		23d. LOCATION (City, town, or county) (State) <u>Gaithersburg Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gaithersburg</u>		25. REC'D BY REGISTRAR <u>Arthur S. Krause</u>	
25a. DATE <u>MAR 30 '60</u>		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 265 5-27-60 ans										
3537										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia b. COUNTY Y					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-2					
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.					d. STREET ADDRESS 1835 Phelps Place, NW			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Chester Wells Clark					4. DATE OF DEATH Month Day Year March 13 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1896		9. AGE (In years last birthday) 64 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.I.A. Agent		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Frederick Clark					14. MOTHER'S MAIDEN NAME Adelaide Knight					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO None					
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>Cerebral vascular accident</del> 24 hours 1 week 600.0 DUE TO Uremia 20 months Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost } DUE TO (b) <del>Hypertensive Cardiovascular Disease</del> 5 years Hypertensive Cardiovascular Disease 20 months Due to Chronic Renal Disease Pyelonephritis (20 10 years) 10 years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day Year Hour a m p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from March 11, 1960, to March 13, 1960 that I last saw the deceased alive on March 13, 1960, and that death occurred at 3:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3/13/60 National Institutes of Health Bethesda 14, Maryland										
ACTUAL SIGNATURE Charles A. Chidsey, M.D.										
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 3/14/60		22c. NAME OF CEMETERY OR CREMATORY CEDA HILL CREMATORY		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawkers Sons 1756 Penna Ave NW					ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

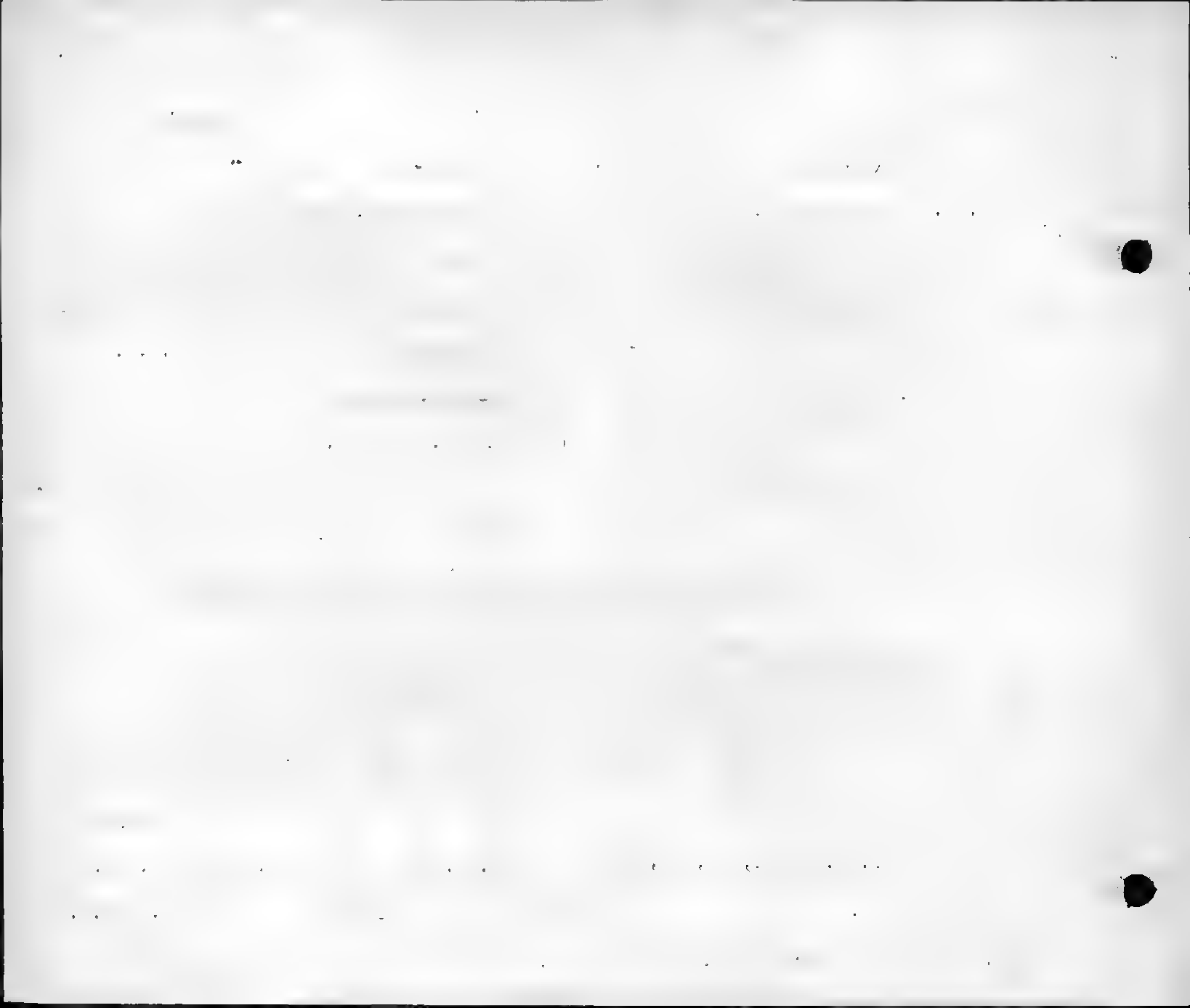
VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3539  
CERTIFICATE OF DEATH

03433

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 1/2 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>5904 Crawford Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy CLEMENT</b>		4. DATE OF DEATH Month Day Year <b>March 25 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-60</b>
9. AGE (In years lost birthday) yrs <b>2</b>		10. IF UNDER 1 YEAR Months Days <b>2 29</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		12. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
13. FATHER'S NAME <b>Billy M. CLEMENT</b>		14. MOTHER'S MAIDEN NAME <b>Sarah K. USSERLY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) Billy M. Clement, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO <b>Primary atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immaturity (1# 2 oz)</b> DUE TO (c) <b>always</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 1/2 hrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the assistant) attended the deceased from <b>3/25 1960</b> to <b>3/25 1960</b> that (I) (we) last saw the deceased alive on <b>3/25 1960</b> , and that death occurred at <b>1005A</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>G. B. Avery</b>		22b. DATE SIGNED <b>3-25-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Ship</b>		23b. DATE THEREOF <b>3-26-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Norwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Norwood, Stanley Co. N.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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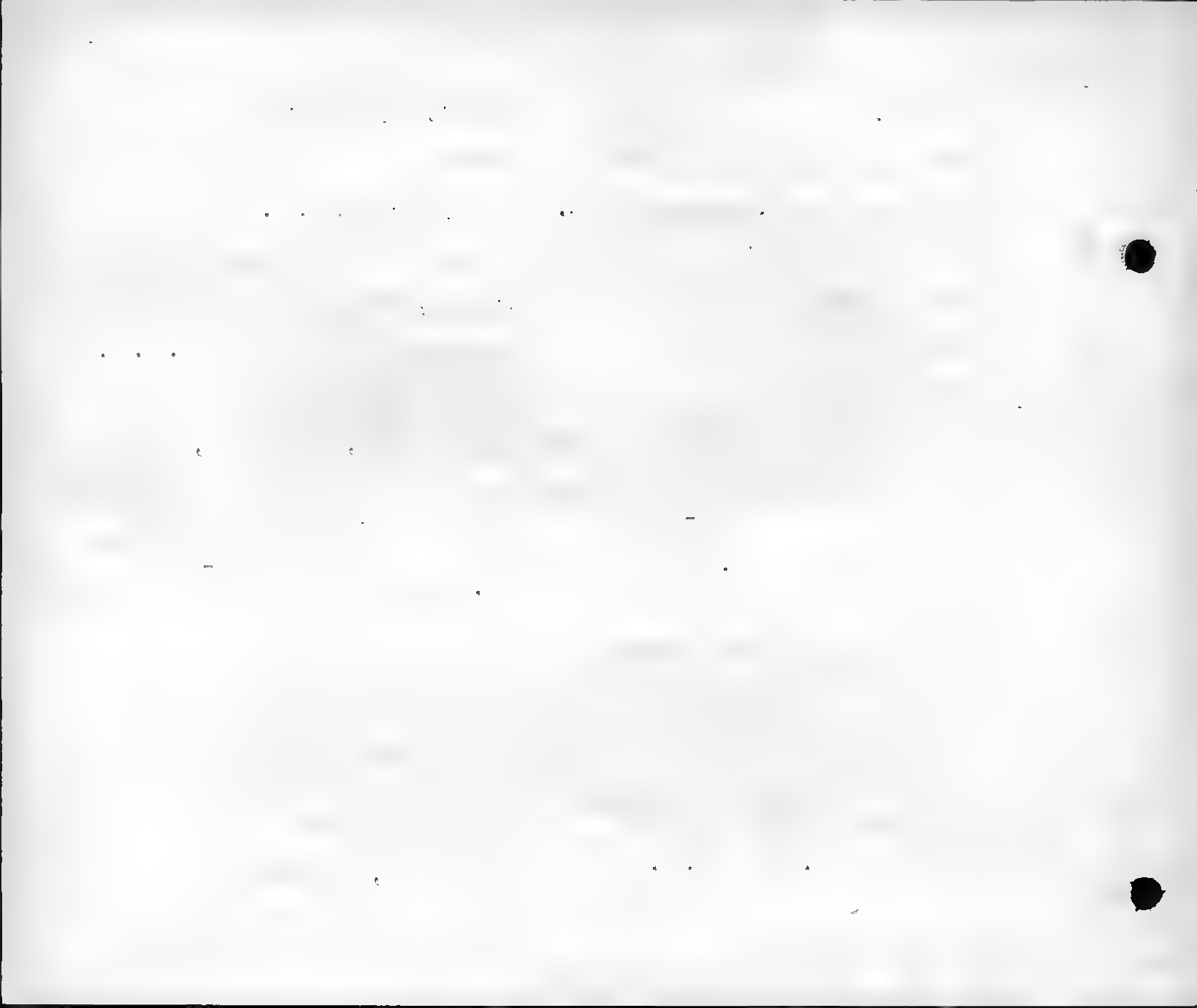


3529

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>31 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Millie</b> Middle <b>(None)</b> Last <b>Conn</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 18, 1879</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. AGE (In years last birthday) <b>80</b> yrs.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Williams</b>				14. MOTHER'S MAIDEN NAME <b>Willie Ann (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>Unascertainable</b>			
17. ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory depression</b> DUE TO <b>Post-operative intestinal obstruction, and</b> <b>pneumonia</b> DUE TO <b>1. local pelvic invasion by cancer with intra-</b> <b>abdominal metastases 2. epidermoid carcinoma of</b> <b>the cervix</b> INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b> <b>6 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 17, 1960</b> to <b>March 19, 1960</b> that I last saw the deceased alive on <b>March 19, 1960</b> and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Marvin S. Arons</b> DATE SIGNED <b>3/20/60</b> ACTUAL SIGNATURE <b>Marvin S. Arons</b> M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>3-23-60</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>P. S. Co. Md</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barnes &amp; Matthews</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 22 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>William S. Kenna</b>							





3457

## CERTIFICATE OF DEATH

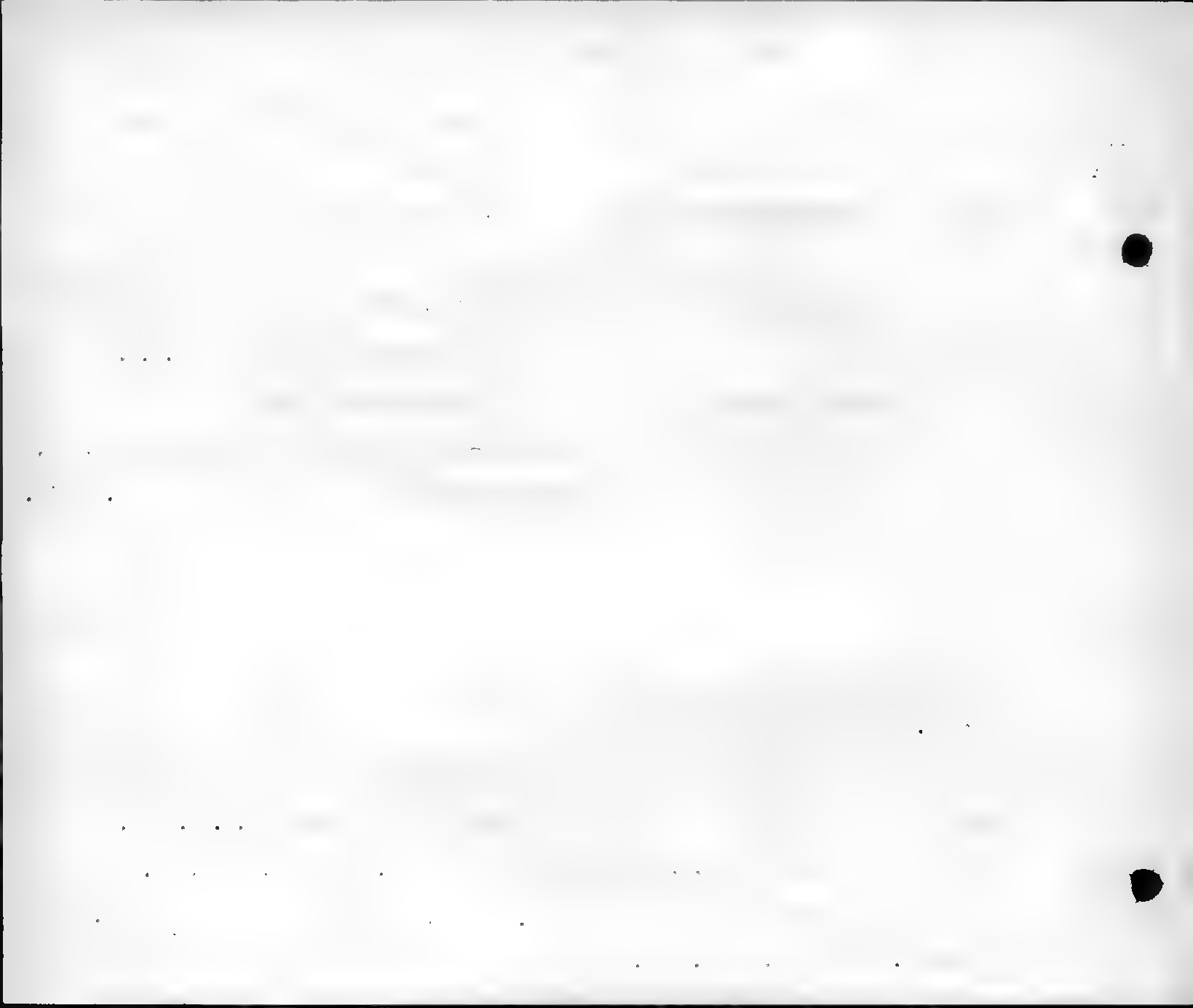
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If instit' on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>5031 Nantucket Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Collins</u>				4. DATE OF DEATH Month Day Year <u>March 9 19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 9, 1960</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde Eugene Collins</u>				14. MOTHER'S MAIDEN NAME <u>Leona Freida Greeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <u>Father - 5031 Nantucket Road, College Pk, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Pulmonary Disease</u> 763- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. <u>1:14pm</u> m. <u>March 9 1960</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Langley Park</u>	
				20f. (City or town) <u>Langley Park</u>		(County) (State)	
21. I certify that I attended the deceased from <u>3/9</u> , 19 <u>60</u> , to <u>3/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8:30 AM 3/9, 1960</u> , and that death occurred at <u>1:14pm</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Murray Paul</u>				ADDRESS (Street, city or town, state) <u>8106 New Hampshire Ave., L.Pk., Md.</u>			
DATE SIGNED <u>March 9, 1960</u>							
PHYSICIAN'S NAME (Type) <u>Murray Paul, M.D. 8106 New Hampshire Ave., Langley, Park, Md.</u>							
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hospital Takoma Park, Md.</u>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. &amp; Hospital</u>				24a. REC'D BY REGISTRAR <u>MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

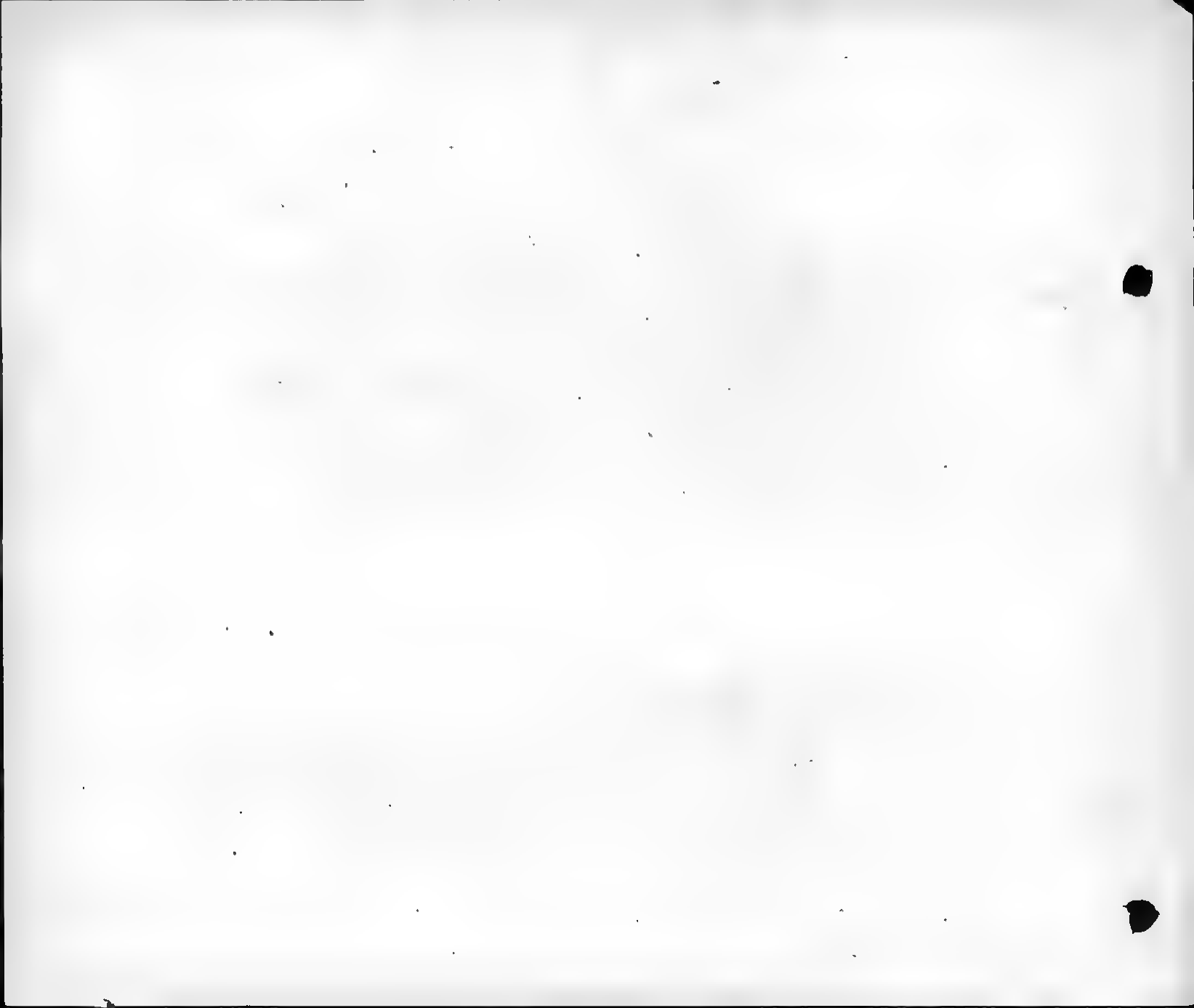
Nov 4/160



## CERTIFICATE OF DEATH

3488

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pahoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San Hosp</u>		e. STREET ADDRESS <u>15922 Rockville</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Marie</u> Last <u>Cranford</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1958</u>
9. AGE (In years) <u>1-8 months</u>		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u>19</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Wm A Cranford</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca L. H.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERSTITIAL (VIRUS) PNEUMONIA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VEGETATIVE BACTERIAL ENDOCARDITIS (MITRAL VALVES)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/30</u> , 19 <u>58</u> , to <u>3/10/1960</u> , that I last saw the deceased alive on <u>3/9/1960</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7030 Carroll Ave. Rockville Md.</u> DATE SIGNED <u>3/10/60</u>			
ACTUAL SIGNATURE <u>Howard B. Morse</u> M.D.		PHYSICIAN'S NAME (Type) <u>Taboma Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>3/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Chase</u>		24a. REC'D BY REGISTRAR <u>5:00 PM</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. Chase</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

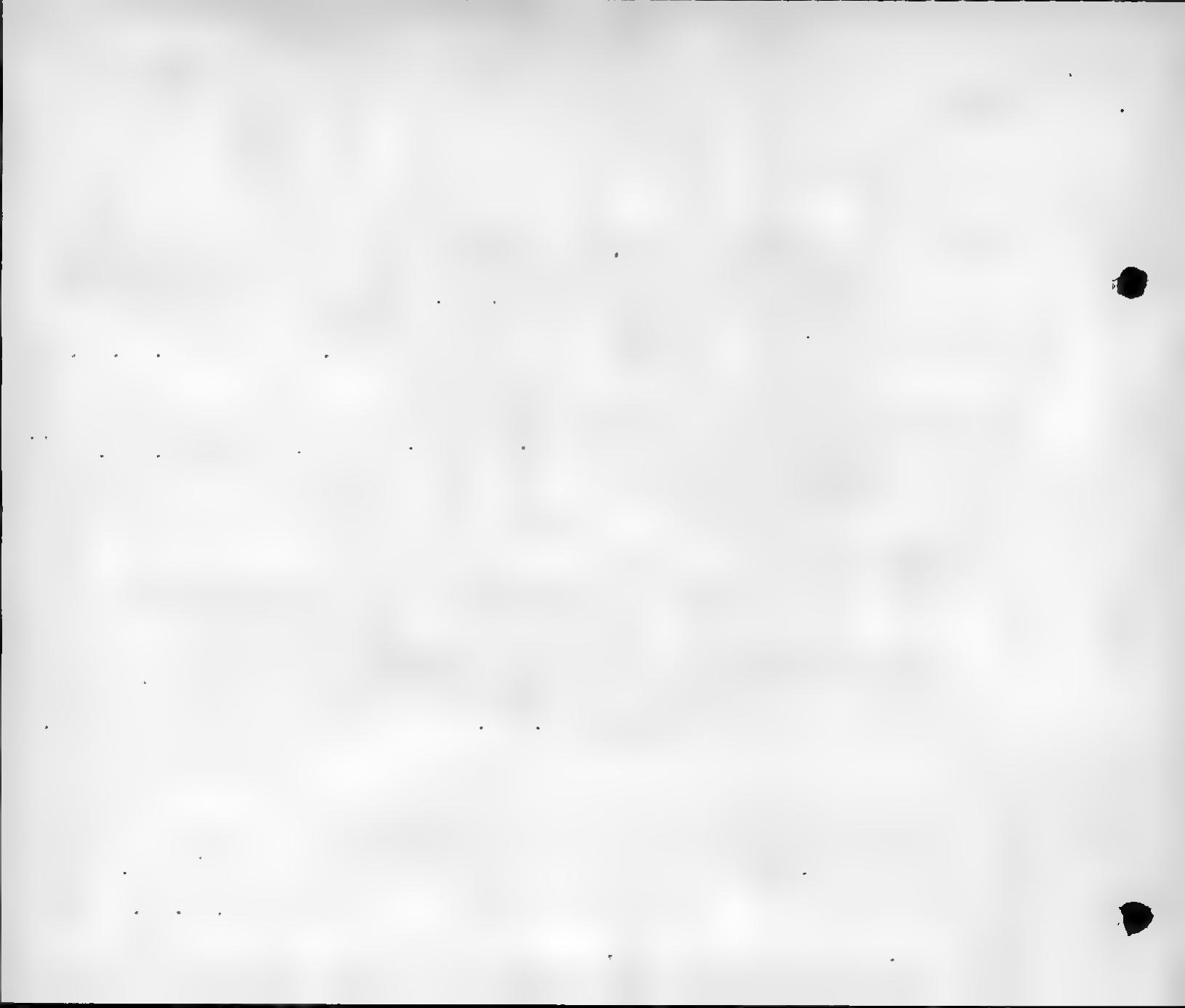
3560 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film Q258 3-10-60 et

03437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>36 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1705 Lanier Place, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>HOLBROOK</b> Last <b>CROISSANT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1875</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Hours <b>84</b> Min. <b>84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter</b> <b>Mrs. Irwin H. Wensink</b> Address <b>4700 Langdrum La., Bethesda, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7025</b> (b) <b>Fracture, Left hip</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>17 hours</b> <b>2 days</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from high curb attempting to take a bus.</b>				
20c. TIME OF INJURY Month, Day, Year <b>11:30 a. m. 3-1- 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wis. Ave. &amp; D. C. Line, Bethesda, Montg. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Mar. 3, 1960</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>Mar 7 '60</b>		
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

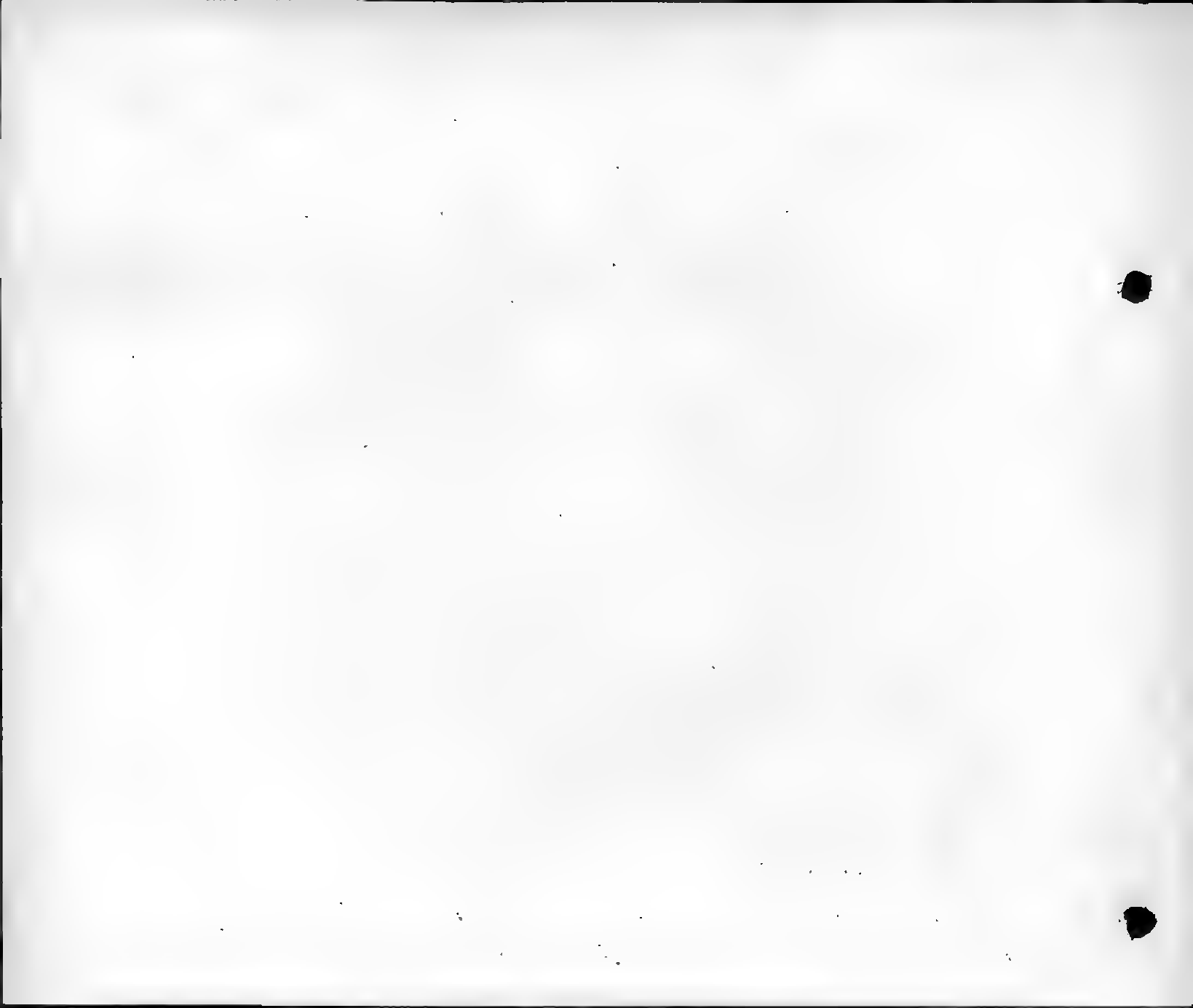
3541

CERTIFICATE OF DEATH

03438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Chevy Chase</b>			
				f. STREET ADDRESS <b>4820 De Russey Pkwy.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cornelia</b> Middle <b>H.</b> Last <b>Cruikshank</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/77</b>	
9. AGE (in years last birthday) <b>82</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Evanston, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Holdbird</b>				14. MOTHER'S MAIDEN NAME <b>M aria Augue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT <b>Mrs. M ary Kyster (Daughter)</b>		Address <b>Same as Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cardiovascular accident</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 15</b> , 19 <b>60</b> , to <b>March 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 1</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr Joseph Kenrick</b>				ADDRESS (Street, city or town, state) <b>6450 Wisconsin Ave, Bethesda, Md.</b>		DATE SIGNED <b>3/1/60</b>	
PHYSICIAN'S NAME (Type) <b>Jos. P. Kenrick</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR. 4, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Mendenhall</b>				ADDRESS <b>816 N. H. St. N.W. Wash D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kenna</b>			





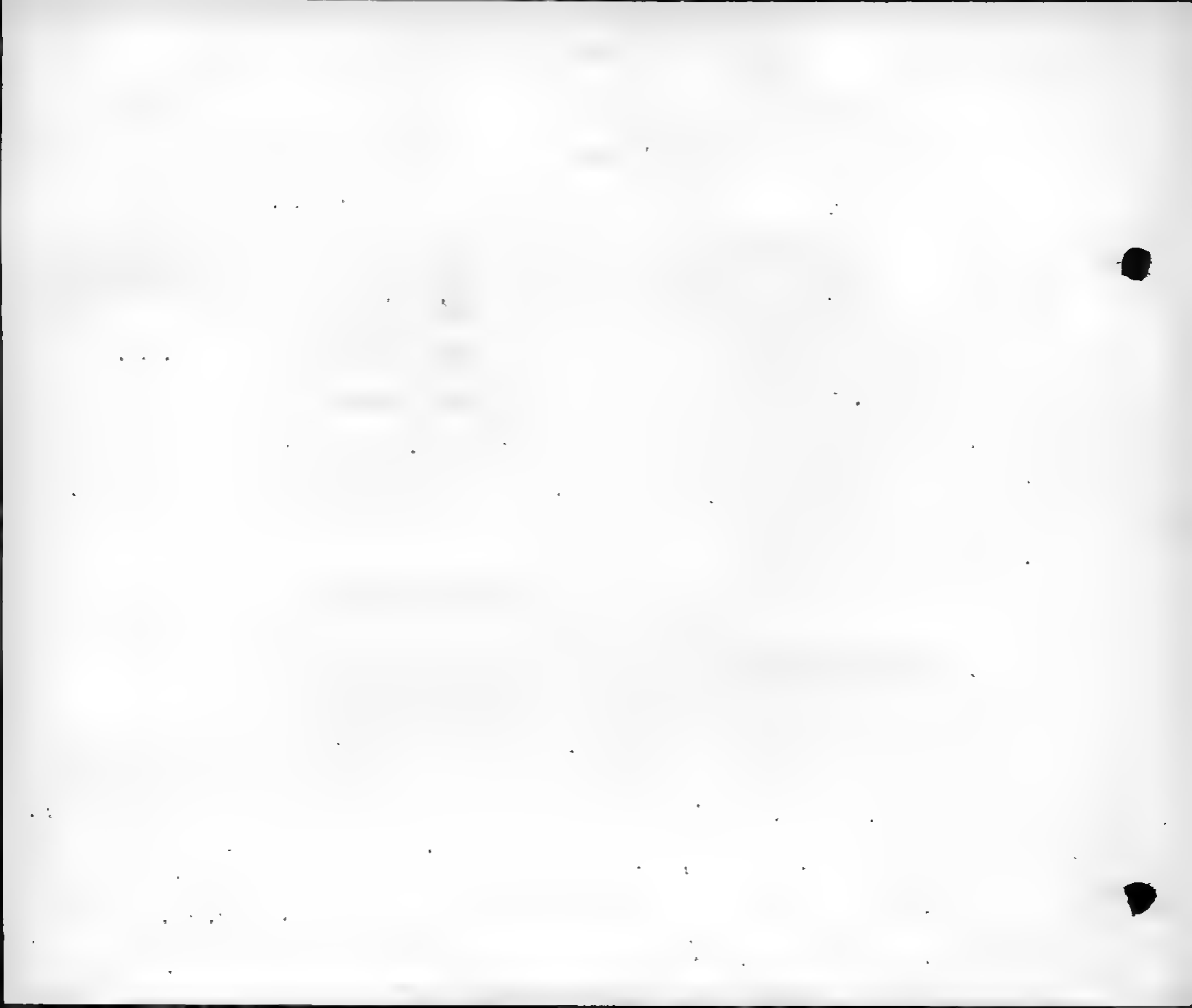
3542  
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
f. STREET ADDRESS <b>4017 Plyers Mill Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle Last <b>Davis</b>		4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan 10, 1885</b>
9 AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles H. Davis</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jenkins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Sister - Mrs. Susan Horn</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bilateral confluent bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>29 February, 1960</b> , to <b>29 February 1960</b> , that I last saw the deceased alive on <b>29 February, 1960</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward S. Witowski</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Suite 400, 8218 Wisconsin Ave., Bethesda 14, Maryland 3/1/60</b>	
PHYSICIAN'S NAME (Type) <b>Edward S. Witowski, Jr.</b>		<b>Bethesda 14, Maryland</b>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/5/60</b>	<b>Ash Memorial,</b>	<b>Sandy Spring, Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Shanderson</b>		ADDRESS	24a REC'D BY REGISTRAR <b>MAR 8 '60</b>
			24b REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
must be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

Dr. Brochart notified  
2



## 3542

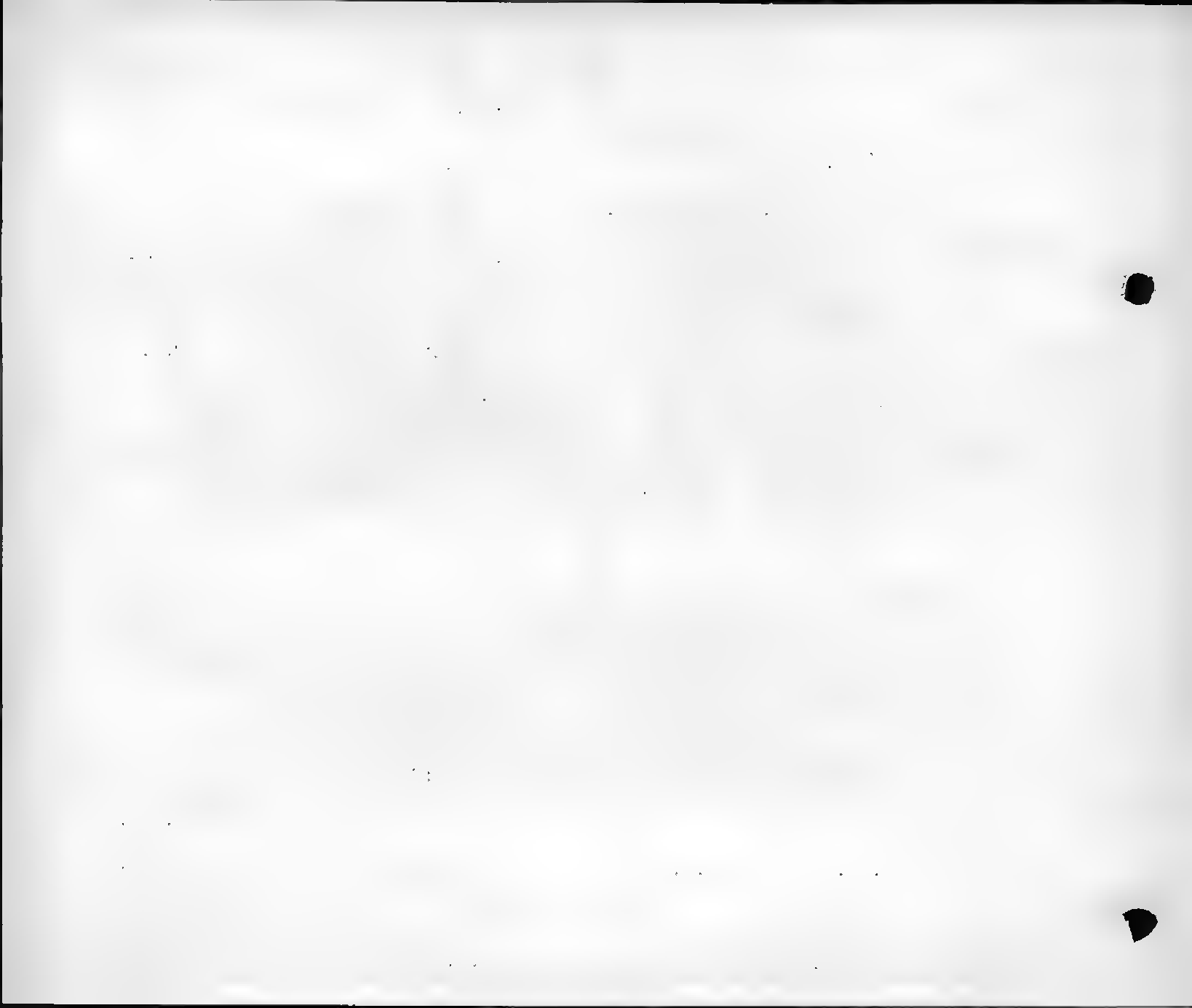
MEDICAL CERTIFICATION

14  
v  
14

be retained by the hospital or attending physician.

**3. FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

1

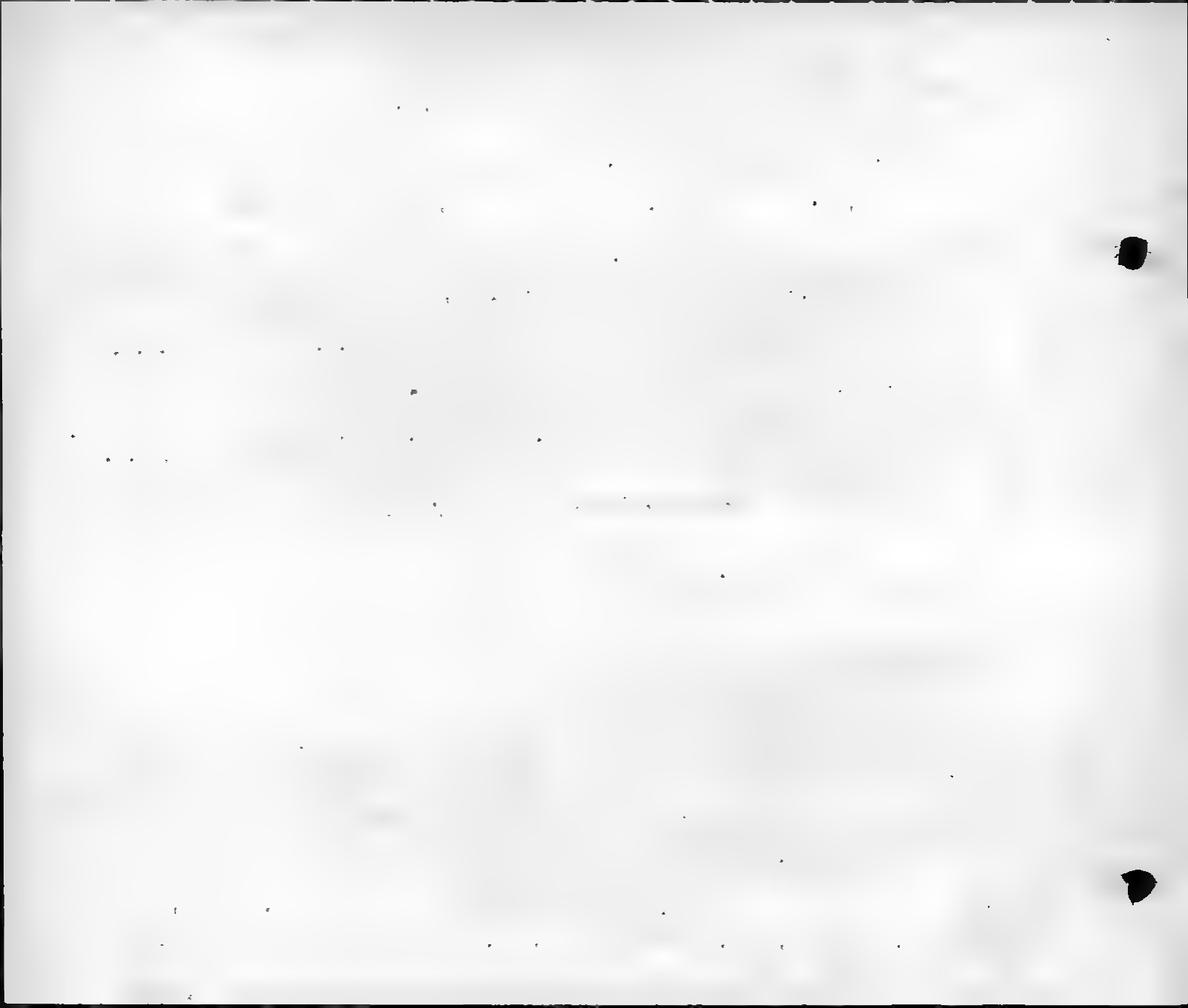
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

343

CERTIFICATE OF DEATH

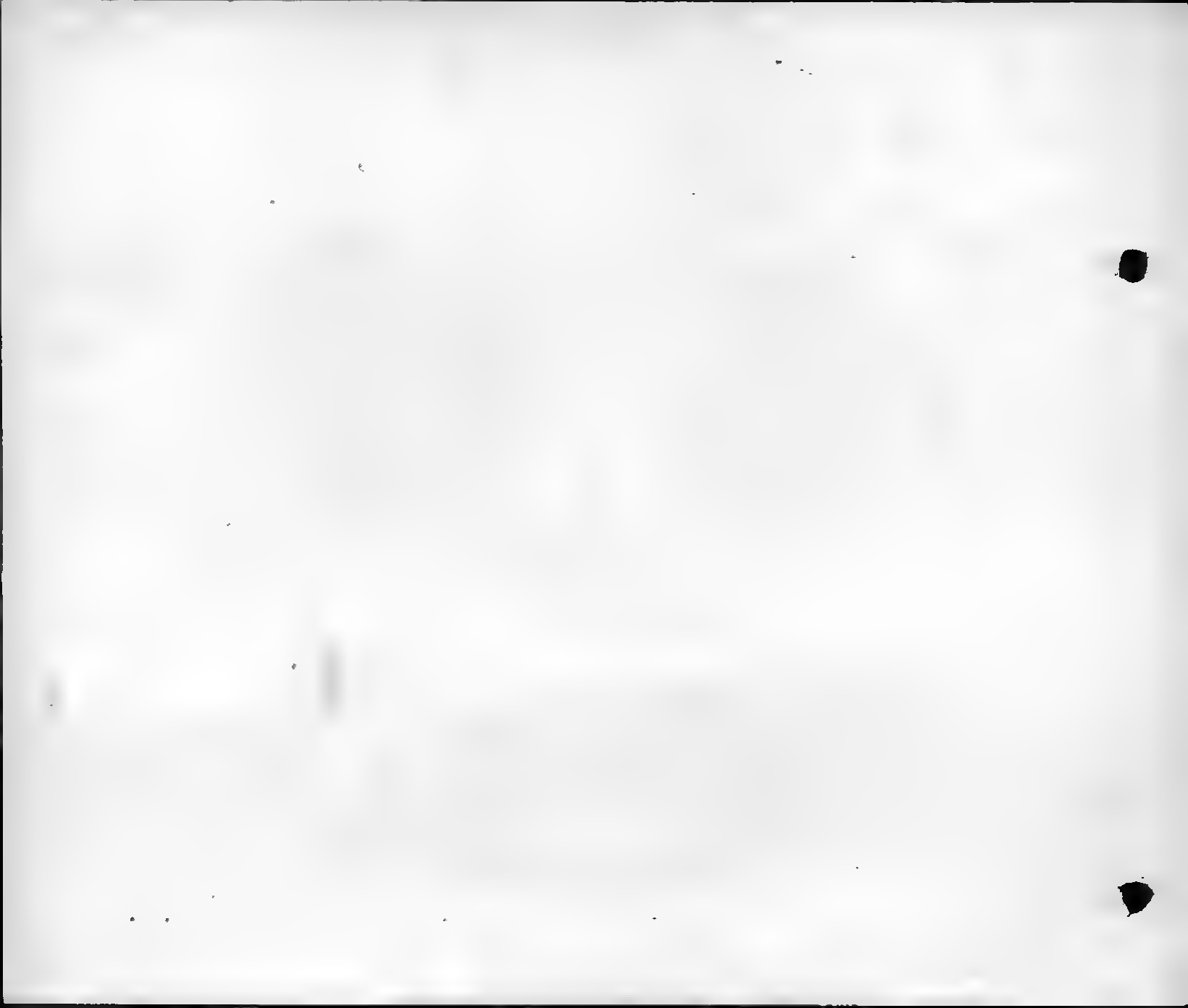
03441

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c LENGTH OF STAY IN 1b <b>9 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12,814 Holdridge Rd.</b>		e. STREET ADDRESS <b>12,814 Holdridge Road</b>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>E.</b> Last <b>DICKENS</b>		4 DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21, 1887</b>
9 AGE (in years last birthday) <b>72 yrs</b>		IF UNDER 1 YEAR: Months <b>2</b> Days <b>19</b> Hours <b>00</b> Min. <b>00</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Winfield Colburn</b>		14. MOTHER'S MAIDEN NAME <b>Ella Burch</b>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>Washington, D.C.</b>	
17 INFORMANT <b>Mrs. Charles C. King, 5501 North Capital St.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malabsorptive Syndrome</b> <b>545 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastrocolostomy Spontaneous</b> DUE TO (c) <b>Malfunctioning gastrojejunostomy</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 yrs</b> <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>June 1945</b> to <b>3-19-1960</b> that (I) (we) last saw the deceased alive on <b>3-17-1960</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a SIGNATURE <b>Samuel M. Bageant</b>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <b>SAMUEL M. BAGEANT</b>		22d ADDRESS <b>5600 N.H. Ave. Wash., D.C.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>3/22/60</b>	
23c NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b>		25a REC'D BY REGISTRAR <b>DATE MAR 22 '60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b REGISTRAR'S SIGNATURE <b>William L. Kuntz</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3544										03442																			
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)																			
a. COUNTY					b. CITY OR TOWN (If outside corporate limits, write nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. STREET ADDRESS					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Montgomery					MARYLAND					Washington, DC					Suburban Hospital					5453 Nebraska Ave. NW									
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH																			
Grace F Dietrick										March 24 1960																			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-10-91		68 yrs		Months		Days		Hours		Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?														
none					none					Pennsylvania					U.S.A.														
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																			
Charles Bauer										Sibert																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT					Address														
no					no					Paul G. Dietrick					(52me)														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior myocardial infarction and beginning dissecting aortic aneurysm										24 hrs																			
411.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) Arteriosclerosis, generalized										10 yrs																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Essential hypertension										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																								
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town)					(County)					(State)				
Hour a m p a. 19					While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																								
21. I certify that (I) (this hospital) attended the deceased from Feb. 1947, to March 24, 1960, that (I) (we) last saw the deceased alive on 3:24 PM, 1960, and that death occurred at 4:37 PM, from the causes and on the date stated above.																													
22a. SIGNATURE										22b. DATE SIGNED																			
Stewart Clapp										3:24:60																			
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																			
Stewart Clapp										3921 Ingomar St NW, Wash DC																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town, or county)					(State)									
removal					3/28/60					Mt. Greenwood Cem.					Luzerne County					Shavertown, Pa.									
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR										25b. SIGNATURE									
The 8th Avenue 2901-14th St NW										MAR 28 '60										C. J. H. H. H.									





3545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. STREET ADDRESS <b>613 Douglas Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>R.</b> Last <b>Dimes</b>		4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/02</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Anna Rebecca Lyles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Dorothy Cooper</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> 332x DUE TO (b) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) <b>Cerebral arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent myocardial infarction</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-2</b> , 1960, to <b>3-5</b> , 1960, that I last saw the deceased alive on <b>3-5</b> , 1960, and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. J. Doyne</b> M.D.		ADDRESS (Street, city or town, state) <b>8106 Maple Ridge Rd, Bethesda, Md</b>	
PHYSICIAN'S NAME (Type) <b>W. J. Doyne</b>		DATE SIGNED <b>3/6/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park.</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



3546

CERTIFICATE OF DEATH

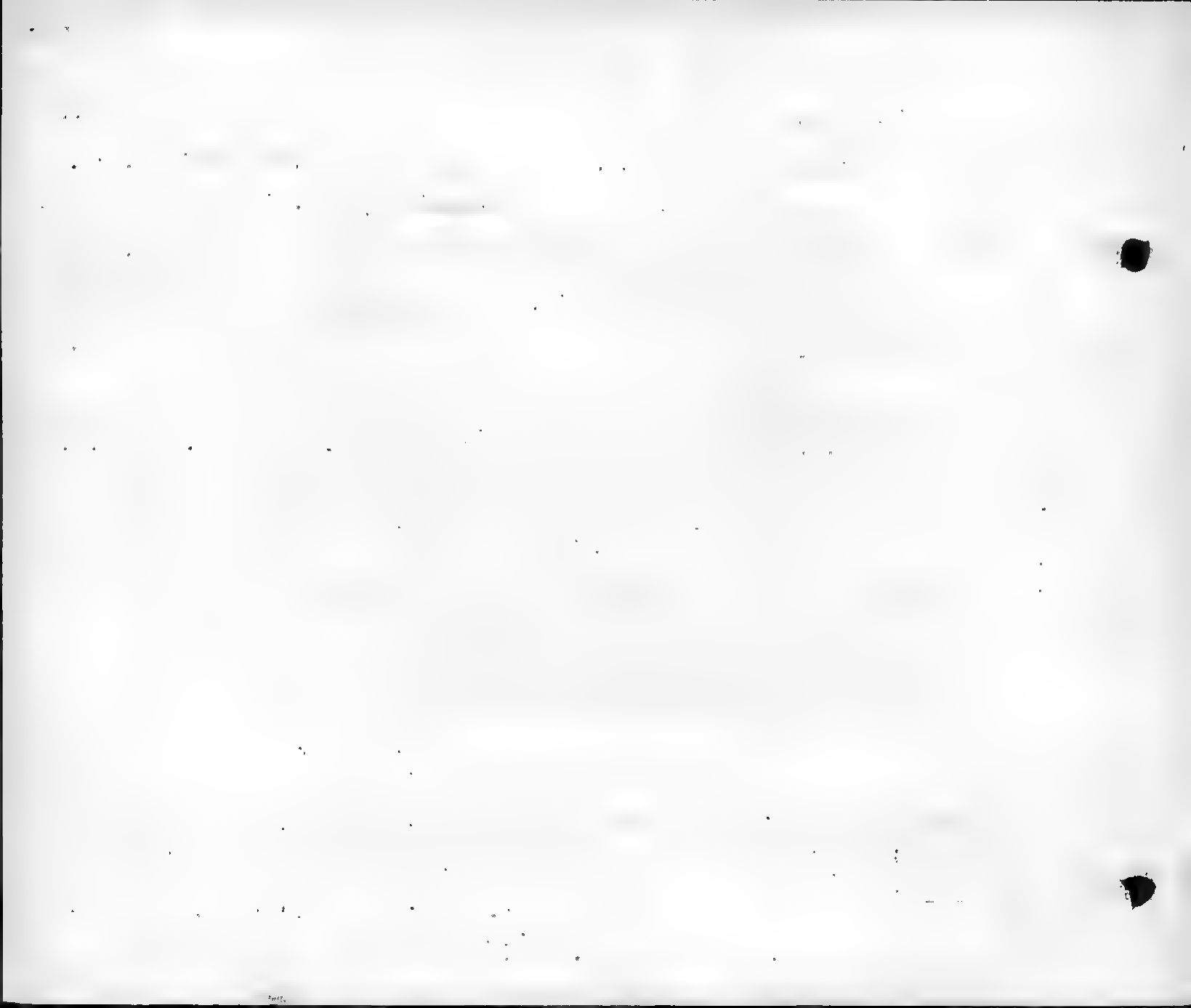
03444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Princes Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum Hts. Hyattsville, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>5710 Chillum Hts. Drive</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD G. DOBY</b>				4. DATE OF DEATH Month Day Year <b>3 / 14 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/22/07</b>		9. AGE (In years last birthday) <b>52</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Script Layer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.C.</b>	
13. FATHER'S NAME <b>Arthur Doby</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>W.W.# 2</b>		INFORMANT Address <b>1105 E. Capitol St. Wash, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary occlusion</b> DUE TO (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>8 Years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>June 1950</b> to <b>March 14, 1960</b> , that I last saw the deceased alive on <b>3-14 1960</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P.P. Andrews</b> M.D.				ADDRESS (Street, city or town, state) <b>4201 Fessenden St NW Washington AC 3-14-60</b>			
PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS M.D.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/17/60</b>			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

Dr. Brochart Notified

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3547

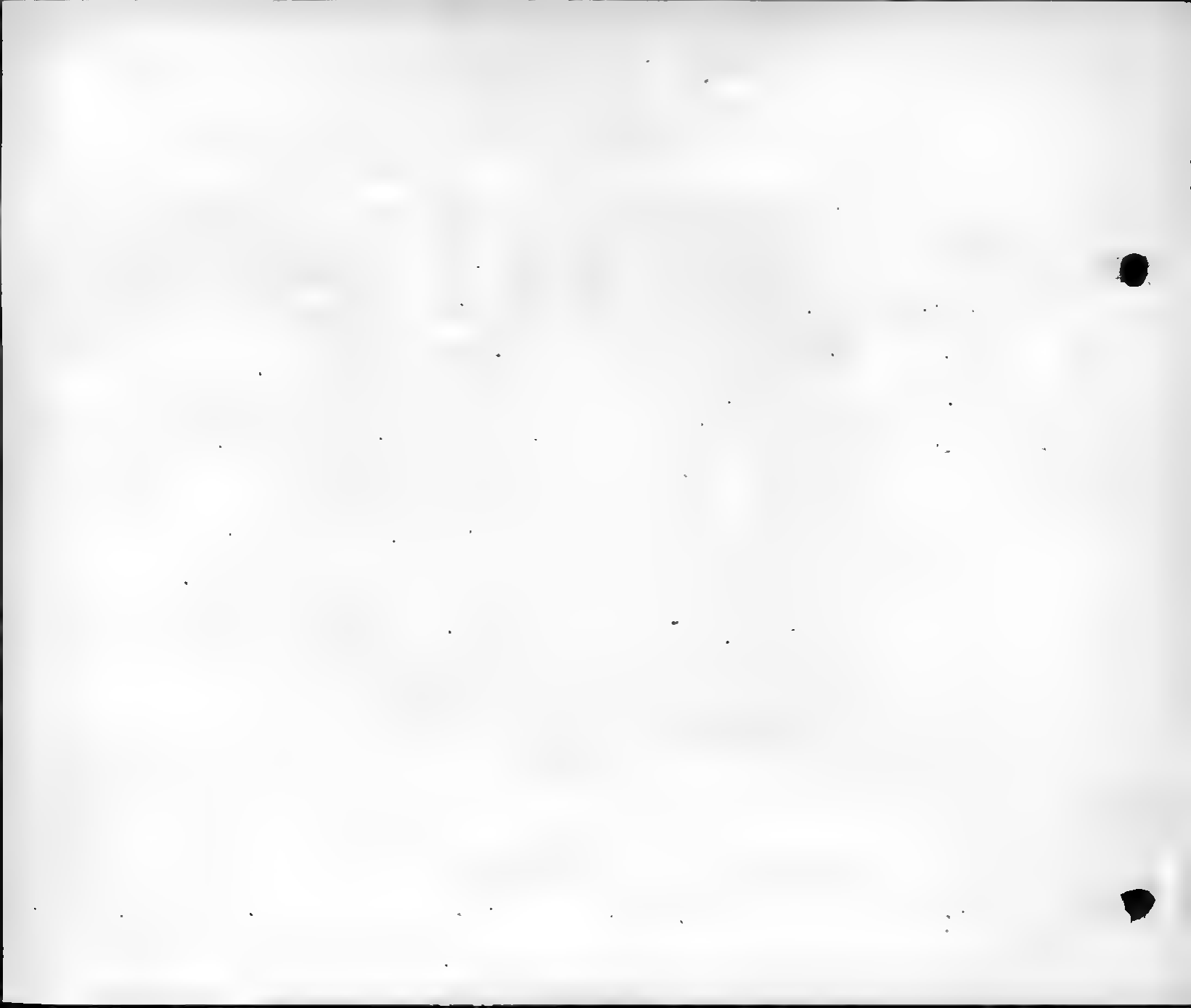
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>3749 Jocelyn St. N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY DOERN</b>		4. DATE OF DEATH Month Day Year <b>MARCH 13 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 20, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Humphrey Falvey</b>		14. MOTHER'S MARDEN NAME <b>Catherine Fitzpatrick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Daughter Bertha D. PETERS SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b> DUE TO <b>Pneumonia embolism</b> (b) <b>162.1</b> DUE TO <b>Bronchogenic carcinoma left lung</b> (c) <b>162.1</b> DUE TO <b>162.1</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 &amp; 4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anteroposterior heart disease with congestive failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 15</b> , 1960, to <b>3/13</b> , 1960, that I last saw the deceased alive on <b>3/13/60</b> , 1960, and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr J Kenrick</b>		ADDRESS (Street, city or town, state) <b>6452 Wisconsin Ave, Bethesda, Md.</b> DATE SIGNED <b>3/13/60</b>	
PHYSICIAN'S NAME (Type) <b>DR JOSEPH KENRICK</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

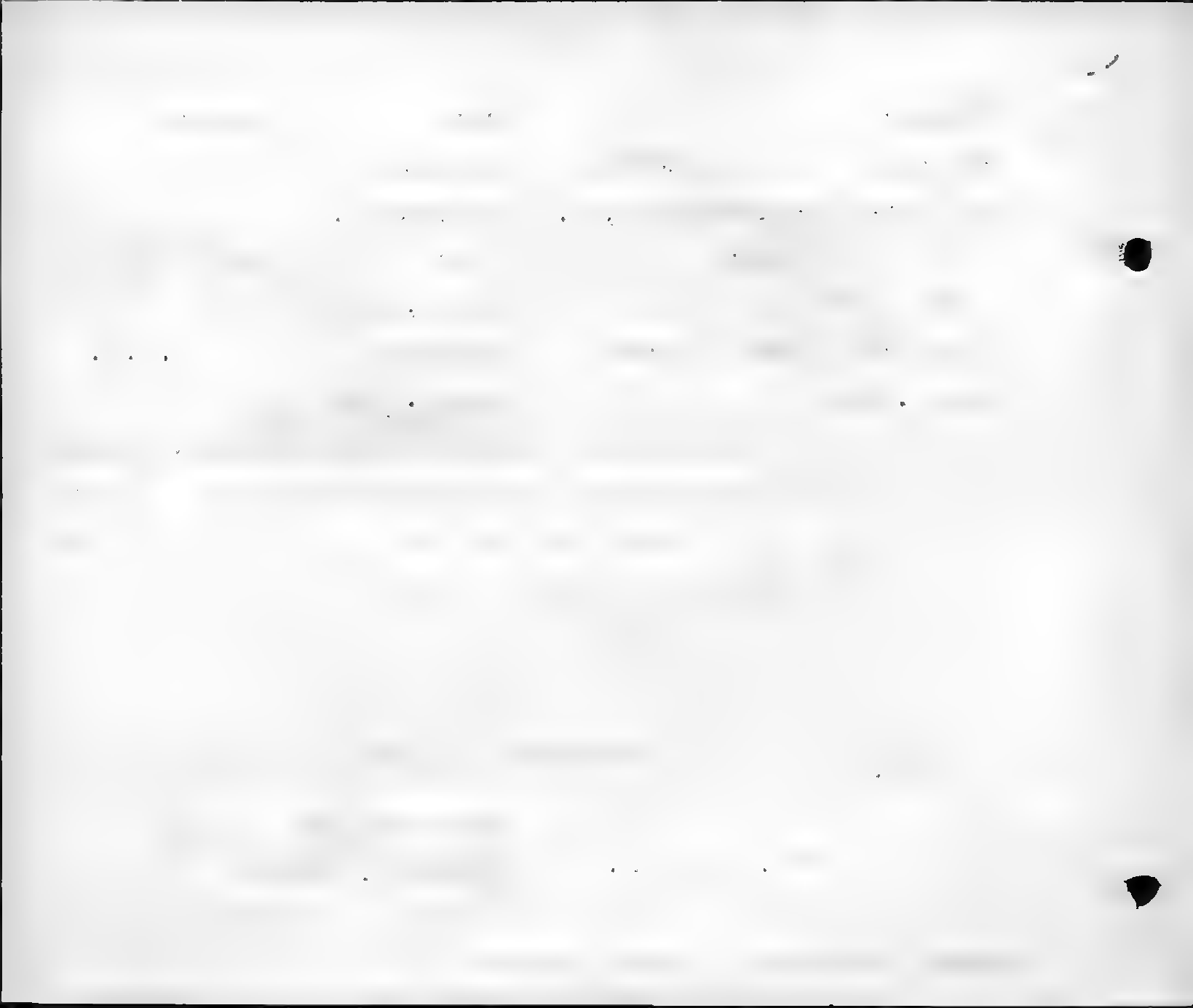
03446

3542

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>86 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert John Derr</b>				4. DATE OF DEATH Month Day Year <b>March 23 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 13, 1919</b>	
9. AGE (In years lost birthday) <b>40</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreign Service Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>			
13. FATHER'S NAME <b>William R. Derr</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn A. Corker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>Unascertainable</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium with cardio-respiratory failure</b> DUE TO <b>194X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary thyroid carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>December 28, 1959</b> to <b>March 23, 1960</b> that I last saw the deceased alive on <b>March 23, 1960</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles E. Mengel, M.D.</b> <b>The Clinical Center</b> <b>March 23, 1960</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL, ETC. <b>CREMATION</b>		22b. DATE THEREOF <b>3/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley Sons</b>				ADDRESS <b>1756 R. Ave. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knorr</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3469  
CERTIFICATE OF DEATH  
03447

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <input checked="" type="checkbox"/> a. STATE <i>New Jersey</i> b. COUNTY <i>Elizabeth</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elizabeth</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		d. STREET ADDRESS <i>20 Vista Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Freda</i> Middle <i>Anna</i> Last <i>Down</i>		4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-22-94</i>
9. AGE (In years last birthday) <i>65</i> yrs		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Carl Schenk</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Restida</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>226</i>	
17. INFORMANT <i>Washington Sanitarium &amp; Hosp. Records</i>		Address <i>Washington Sanitarium &amp; Hosp. Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic Cancer</i> <i>155.1</i> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma Cervicis Uteri</i> DUE TO (c) <i>Cervical Cancer</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 mos.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> 19 <i>60</i> to <i>March 14</i> 19 <i>60</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , and that death occurred at <i>19</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Lysle Williams</i> M.D.		22b. DATE SIGNED <i>3/15/1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>LYSLE WILLIAMS</i>		22d. ADDRESS <i>8700 Columbia Pike, Silver Spring, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>March 18, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Restland Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>East Hanover, New Jersey</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walter</i>		ADDRESS <i>254 Cornell St. D.W.</i>	
25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>MAR 16 '60</i>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

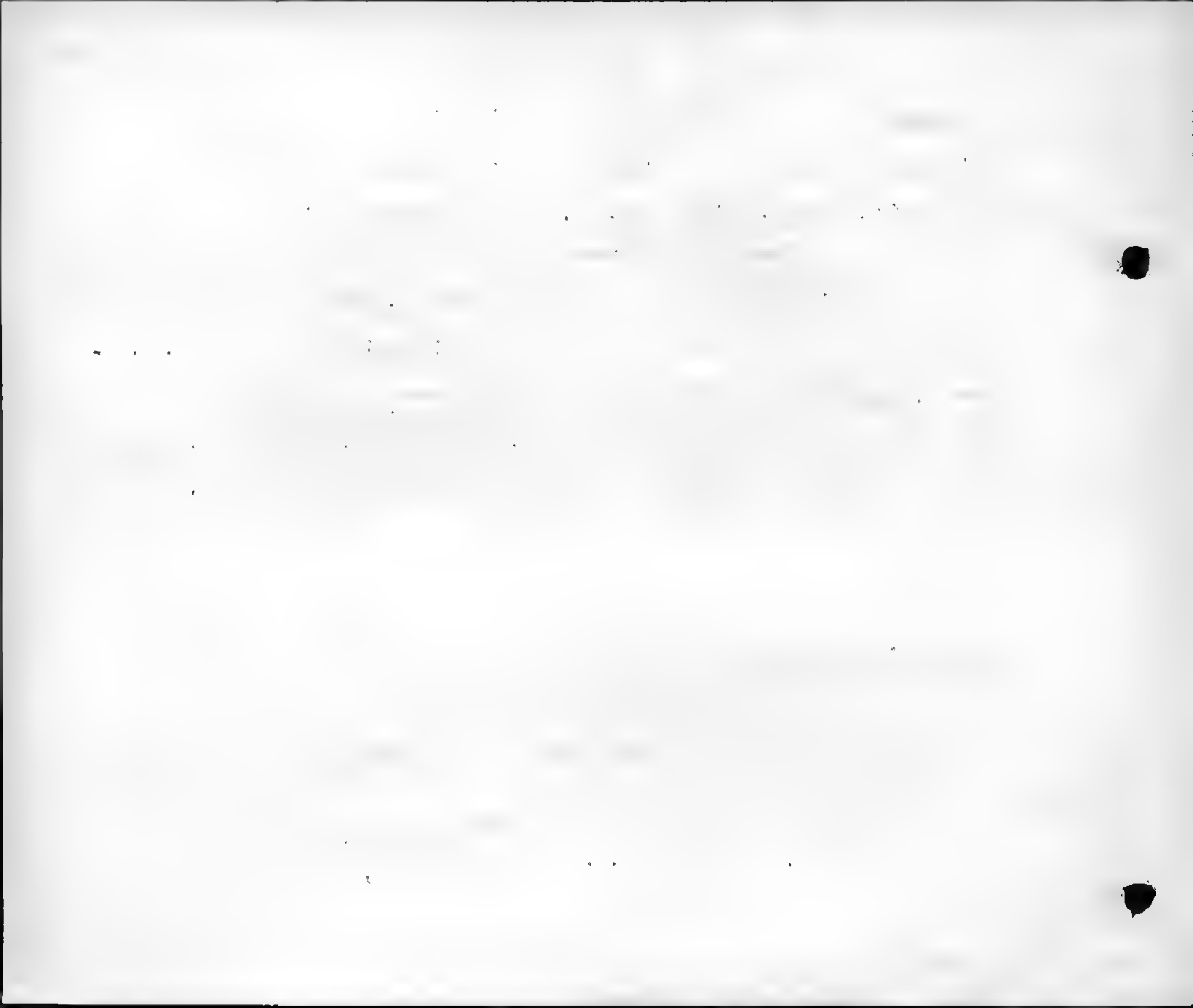
03448

3549

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>			
c. LENGTH OF STAY IN 1b <b>7 days</b>				d. STREET ADDRESS <b>430 Crosswoods Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First <b>Tomas</b> Middle <b>Mateo</b> Last <b>Dreyfuss</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 15, 1951</b>		9. AGE (In years last birthday) <b>8</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John T. Dreyfuss</b>				14. MOTHER'S MAIDEN NAME <b>Janis Behr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Cerebellar and Subarachnoid Hemorrhage.</b>							
204.3 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Secondary Acute Leukemia</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21 I certify that I attended the deceased from <b>February 23, 1960</b> to <b>March 1, 1960</b> , that I last saw the deceased alive on <b>March 1, 1960</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard C. Lechman</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-1-60</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD C. LECHMAN, M.D.</b>				<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-4-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		22d. LOCATION (City, town, or county) (State) <b>FT MYER VA</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>R. W. Chambers</b> ADDRESS <b>3072 M-Spark</b>				24a. REC'D BY REGISTRAR <b>W. D. C.</b> DATE <b>MAR 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

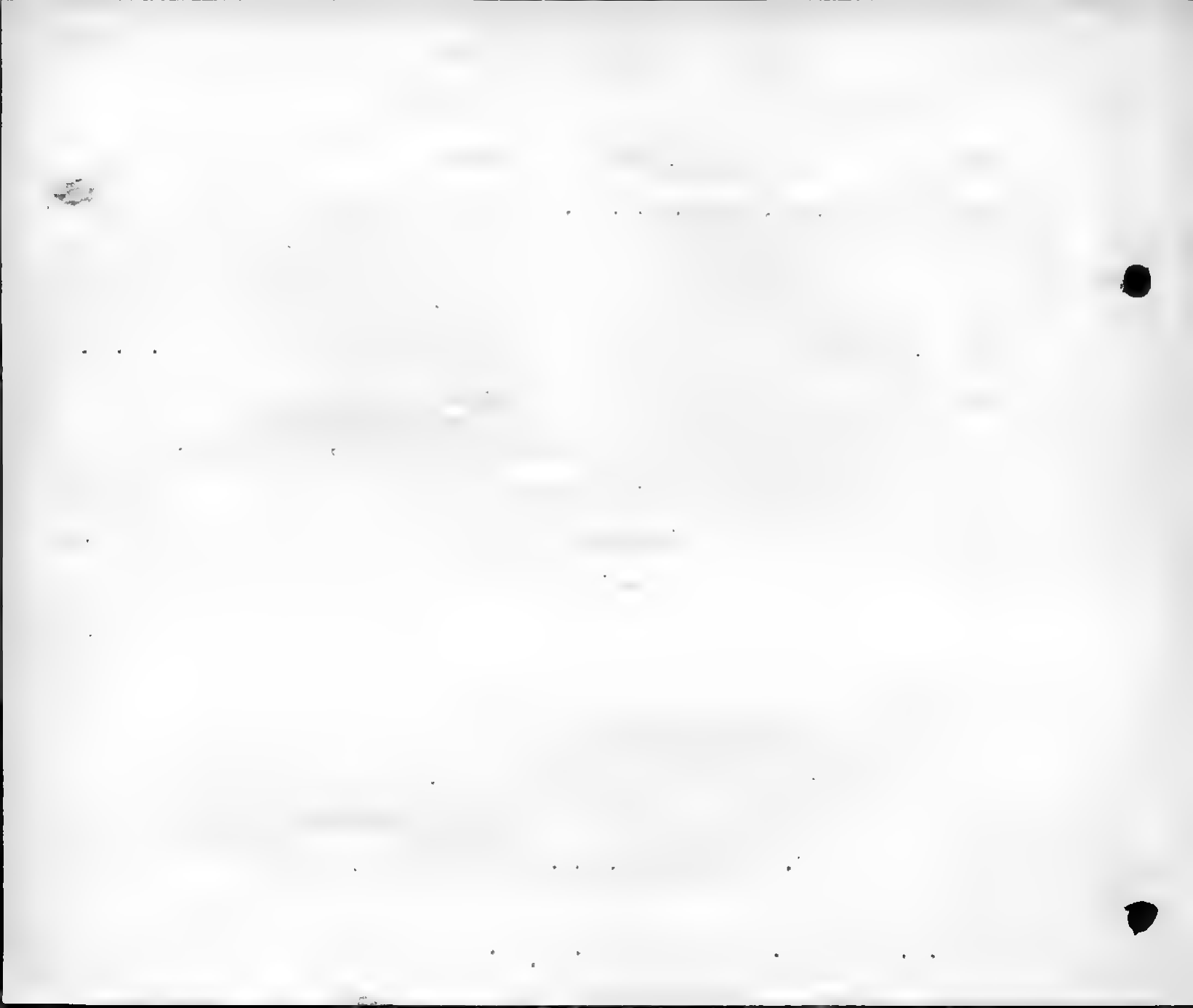


3550

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>14 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Geneva</b> Middle <b>(None)</b> Last <b>Duff</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1943</b>
9. AGE (In years last birthday) <b>16</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Student)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jimmie Duff</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Everson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO <b>410X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral insufficiency</b> DUE TO (c) <b>Rheumatic fever</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>14 years</b> <b>14 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 28, 1960</b> to <b>March 13, 1960</b> that I last saw the deceased alive on <b>March 13, 1960</b> , and that death occurred at <b>1:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. C. Brockenbrough, M.D.</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edwin C. Brockenbrough, M.D.</b>		DATE SIGNED <b>3/13/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>3/14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>--</b>	22d. LOCATION (City, town, or county) (State) <b>Hazard, Kentucky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W.</b> <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 15 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

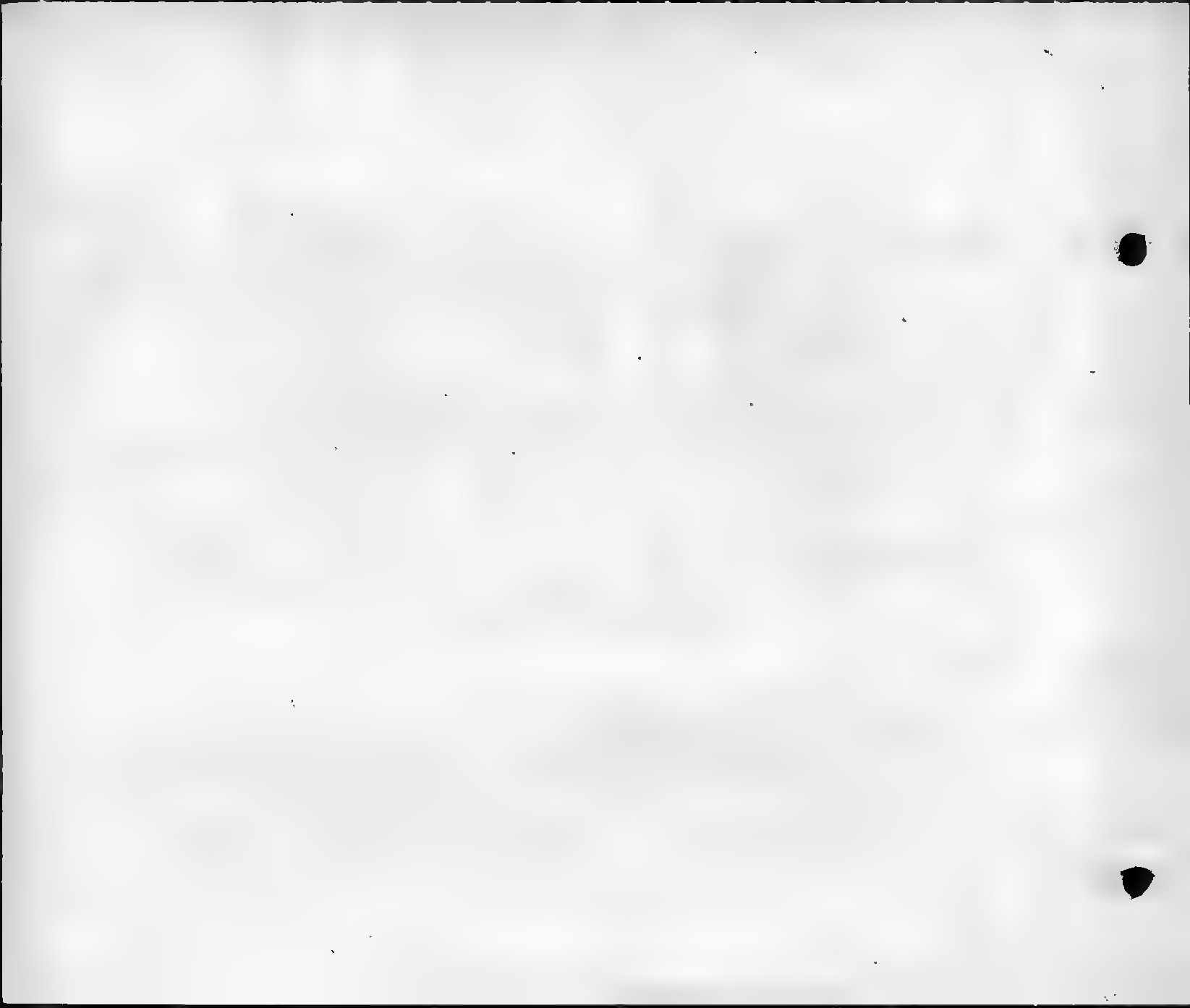
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03450

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 15 <u>9 yrs</u>				d. STREET ADDRESS <u>4721 Chelsea Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4721 N. Chelsea Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Brook</u> Last <u>DuQuoin</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. Int. Rev. Int. Revenue</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Del.</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Andrew E. DuQuoin</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Smoot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO <u>Unknown</u>			
17. INFORMANT <u>Sister</u>				Address <u>Mrs. John Warner-Clinton, Illinois</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Secobarbital poisoning</u> DUE TO <u>970</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Found dead in bed</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				DATE SIGNED <u>3-9-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3552

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03451

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>BURTONSVILLE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURTONSVILLE</b>		d. STREET ADDRESS <b>2711 DUVAL ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES LEWIS DUVAL</b>		First <b>CHARLES</b>		Middle <b>LEWIS</b>		Last <b>DUVAL</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/29/84</b>		9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>WILLIAM SPENCER DUVAL</b>				14. MOTHER'S MAIDEN NAME <b>SARA ANNA ROCH</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>				Address <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ANEMIA</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) <b>ADENOCARCINOMA OF PROSTATE WITH METASTASES</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>2 YEARS</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>OLNEY, MD.</b>		(County) <b>OLNEY, MD.</b>		(State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/25/59</b> , 19____, to <b>3/4/60</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/22/60</b> , 19____, and that death occurred on <b>3/4/60</b> , 19____, from the causes and on the date stated above											
22a. SIGNATURE <b>C. H. Ligon, M.D.</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3/4/60</b>							
22c. PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City or town, or county) <b>Burtonsville Md</b>		(State) <b>Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Witherspoon, Funeral Home</b>		ADDRESS <b>W. W. Witherspoon, Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					



3508

CERTIFICATE OF DEATH

03452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>47x</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2022 Naylor Rd. S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>H.</b> Last <b>DUVALL</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-73</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	11. IF UNDER 24 HRS Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Duvall</b>		14. MOTHER'S MAIDEN NAME <b>Mary ??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>578-10-8546</b>	
17. INFORMANT <b>Mrs Dora C Duvall</b>		Address <b>-2022 Naylor Rd S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>445X</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 13, 1958</b> to <b>MARCH 12, 1960</b> , that I last saw the deceased alive on <b>MARCH 12, 1960</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Allegan Fordice</b> M.D.		ADDRESS (Street, city or town, state) <b>5206 Naylor Rd</b> DATE SIGNED <b>3/12/60</b>	
PHYSICIAN'S NAME (Type) <b>Cheng Cheng, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-15-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 15 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



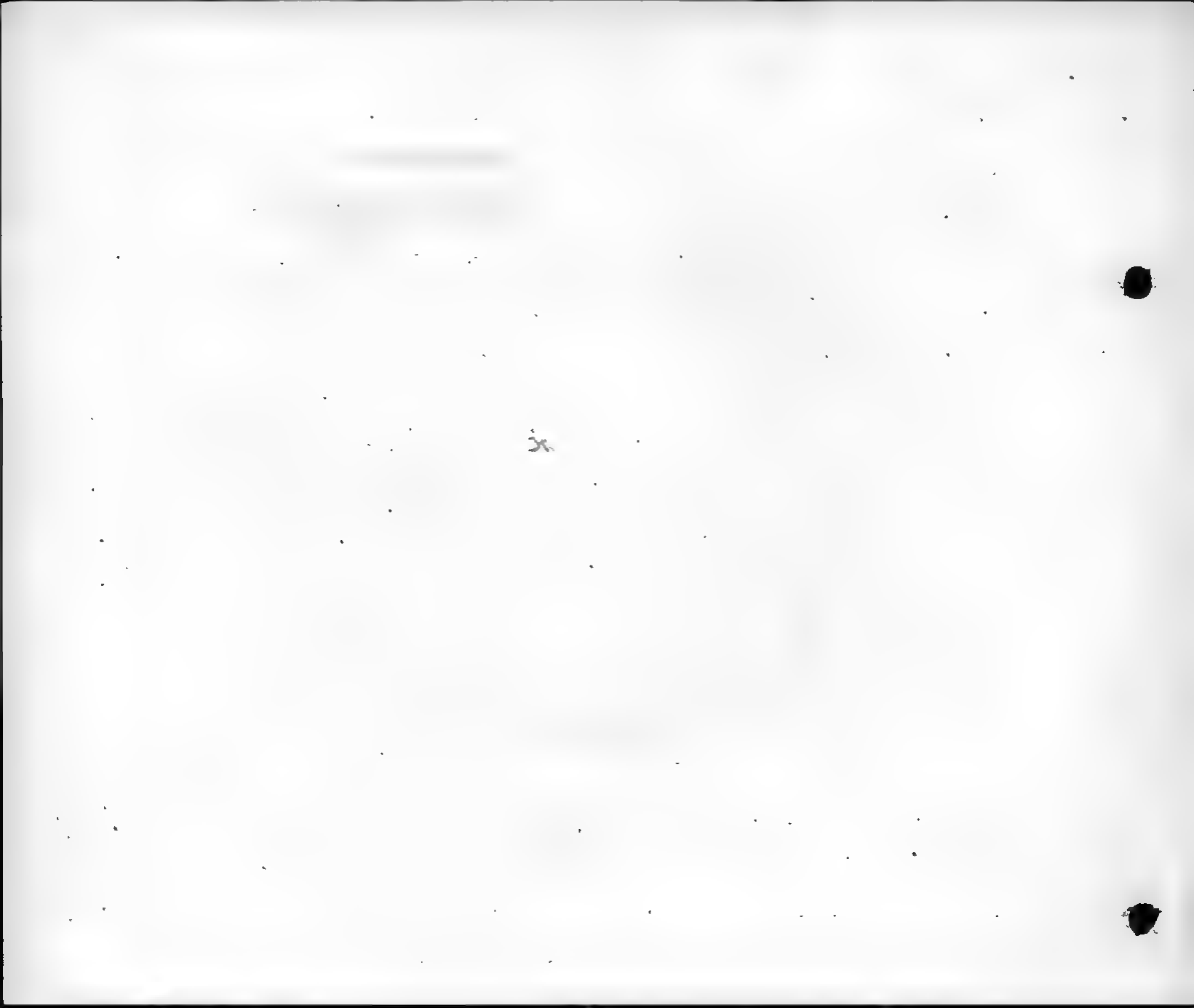
3552

CERTIFICATE OF DEATH

Reg. Dist. No.

03453

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>7da.</u>				d. STREET ADDRESS <u>5715 Arundel Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Barnes Edwards</u>				4. DATE OF DEATH Month Day Year <u>March 31 1960</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-21-75</u>	9 AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Alice Burkes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16 SOCIAL SECURITY NO. <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 24, 1960</u> to <u>March 31, 1960</u> that I last saw the deceased alive on <u>March 31, 1960</u> , and that death occurred at <u>6:38 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Bowditch Hunter, Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>809 Vicksburg Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>				DATE SIGNED <u>3/31/60</u>			
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>4-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. E. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

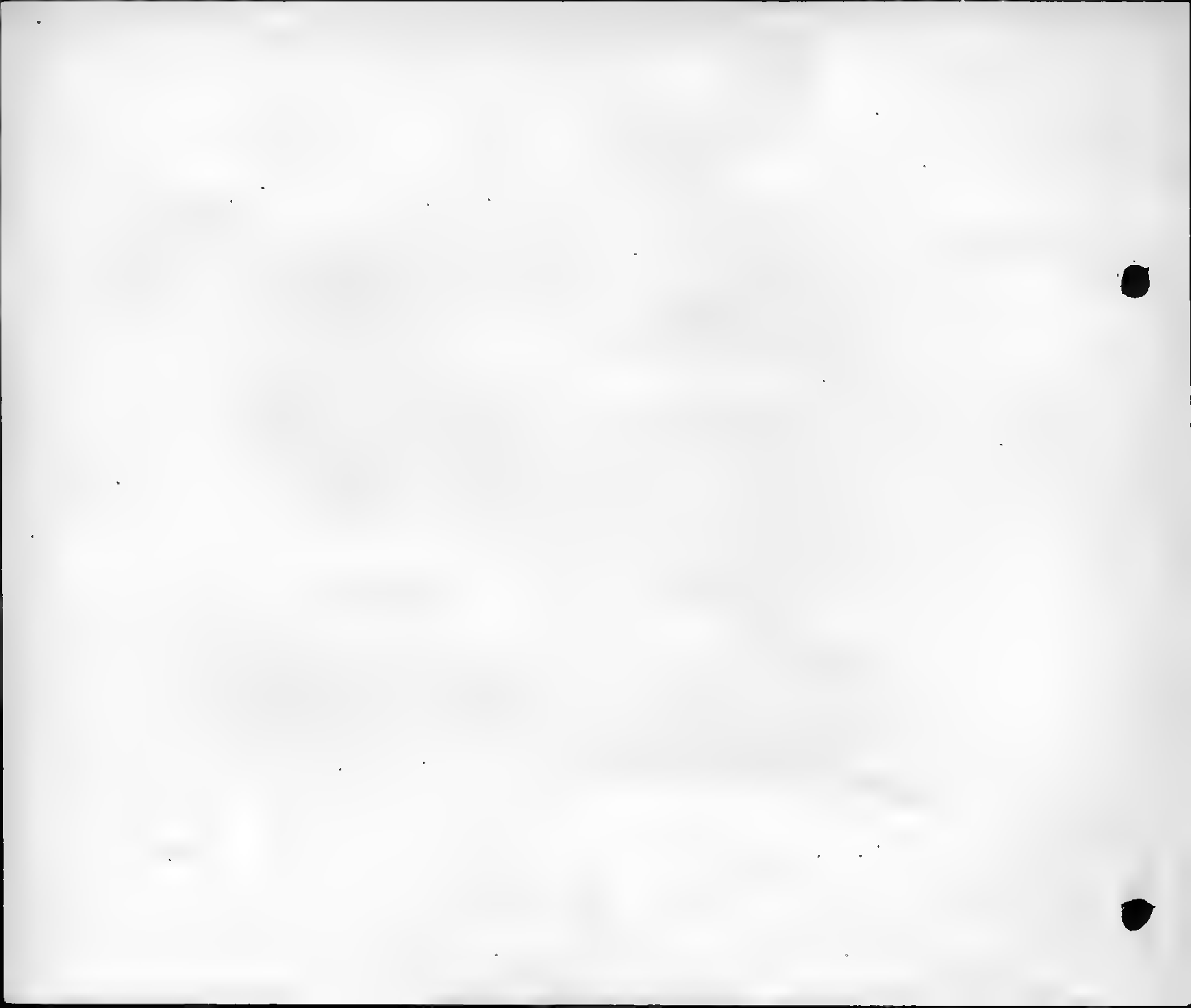
3470

3470

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03454

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dist.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
3. NAME OF DECEASED (Type or print) First <i>Jessie</i> Middle <i>Elizabeth</i> Last <i>Emmert</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>24</i> - Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-5-04</i>
9. AGE (In years last birthday) <i>55</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rural</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.-9.</i>	
13. FATHER'S NAME <i>John Rider</i>		14. MOTHER'S MAIDEN NAME <i>Florence Shaver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>577-52-0350</i>	
17. INFORMANT <i>Washington Sanitarium + Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i> 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Partial Bowel Obstruction</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) and (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>12/8/59</i> <i>3/24/60</i>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>12/8/59</i> to <i>3/24/60</i> , that (I) (we) last saw the deceased alive on <i>3/24/60</i> , and that death occurred at <i>6:55 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>H. T. Morse</i> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <i>Mar. 24, 1960</i>			
22c. PHYSICIAN'S NAME (Type) <i>H. T. MORSE</i>			
22d. ADDRESS <i>7030 Carroll Ave., Takoma Park, Md.</i>			
23a. BURIAL CREMATION REMOVAL (Spec. fy) <i>Cremation</i>		23b. DATE THEREOF <i>3-25-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Prince George Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>	
25a. REC'D BY REGISTRAR <i>Mar 28 '60</i>		25b. REGISTRAR'S SIGNATURE <i>C. L. S. K. H. A.</i>	





3556

CERTIFICATE OF DEATH

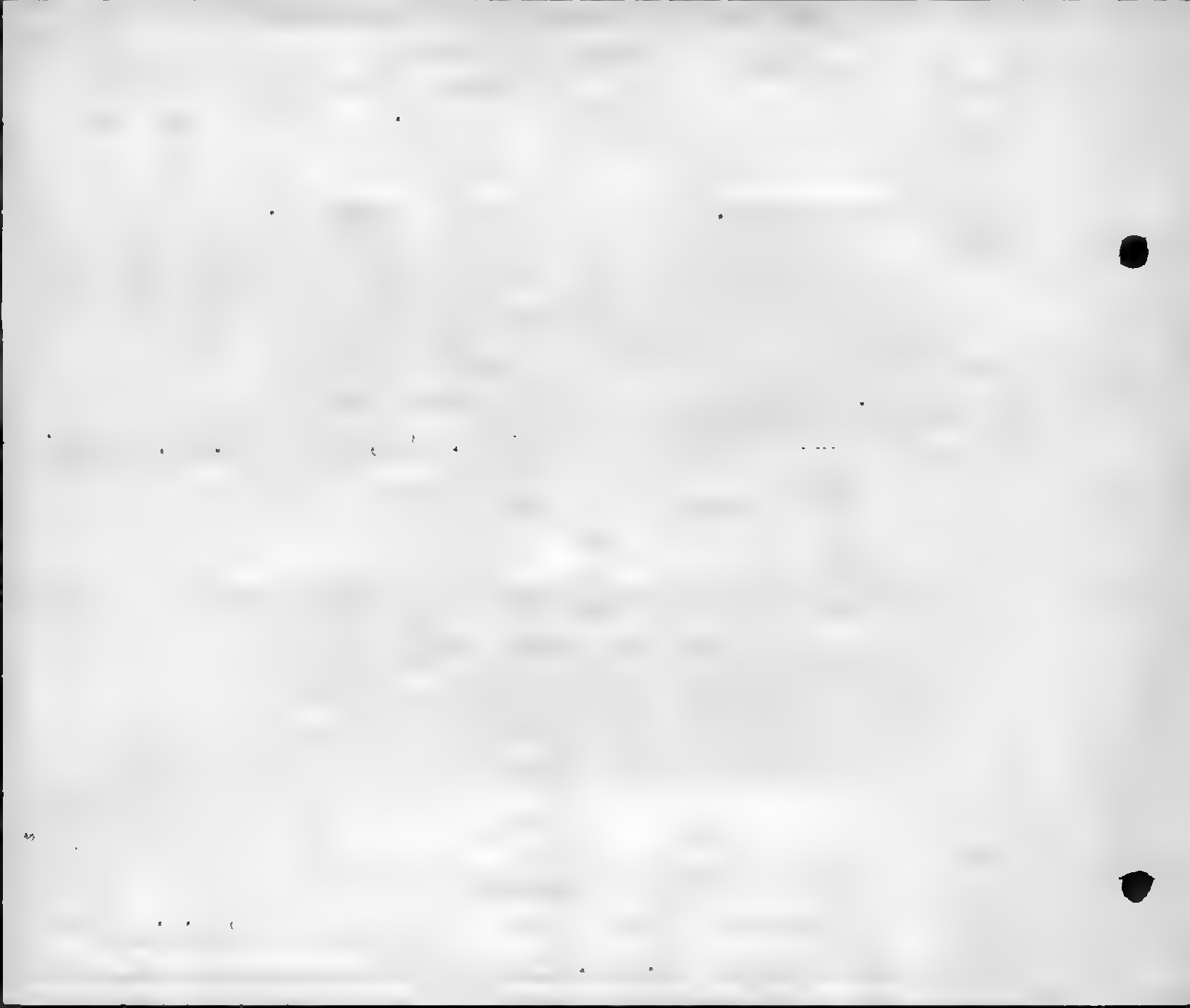
03455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Mont</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>57 Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5314 Baltimore Ave.</b>		d. STREET ADDRESS <b>5314 Baltimore Ave.</b>	
e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First Middle Last <b>E'WE</b>		4. DATE OF DEATH <b>MARCH 27 1960</b> Month Day Year	
5. SEX <b>7</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 June 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis H. Barrett</b>		14. MOTHER'S MAIDEN NAME <b>Annie Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>David L. E'We, 5314 Balto. Ave. Bethesda</b> Address <b>Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.1</b> IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>21 Mar., 1960</b> , to <b>27 Mar., 1960</b> , that I last saw the deceased alive on <b>26 Mar., 1960</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert Martyn Jr.</b> M.D. <b>5029 Bethesda Ave</b>		DATE SIGNED <b>27 Mar 60</b>	
PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN JR</b>		<b>Bethesda Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>3/28/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion</b>	22d. LOCATION (City, town, or county) (State) <b>Northfield, N.J.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Truitt Smith</b> ADDRESS <b>1756 Pa. Ave. NW DC</b>		24a. REC'D BY REGISTRAR <b>MAR 29 60</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Miller</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3555

## CERTIFICATE OF DEATH

Reg. Dist. No.

03456

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Since 2/2/1959</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Forney</u>		4. DATE OF DEATH Month <u>3</u> Day <u>38</u> Year <u>1968</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Margaret Wynkoop</u> Address <u>6421 Broad St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>with slowly progressive</u> <u>deterioration</u> DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>		20c. TIME OF INJURY Month. <u>19</u> Day. <u></u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I attended the deceased from <u>August 16, 1954</u> to <u>March 28, 1960</u> , that I lost saw the deceased alive on <u>March 28, 1960</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D. <u>8601 Old Georgetown Rd</u>		DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>		ADDRESS (Street, city or town, state) <u>Bethesda 14 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-31-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u> ADDRESS <u>2224 Wisconsin N.W. - D.C.</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hauer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



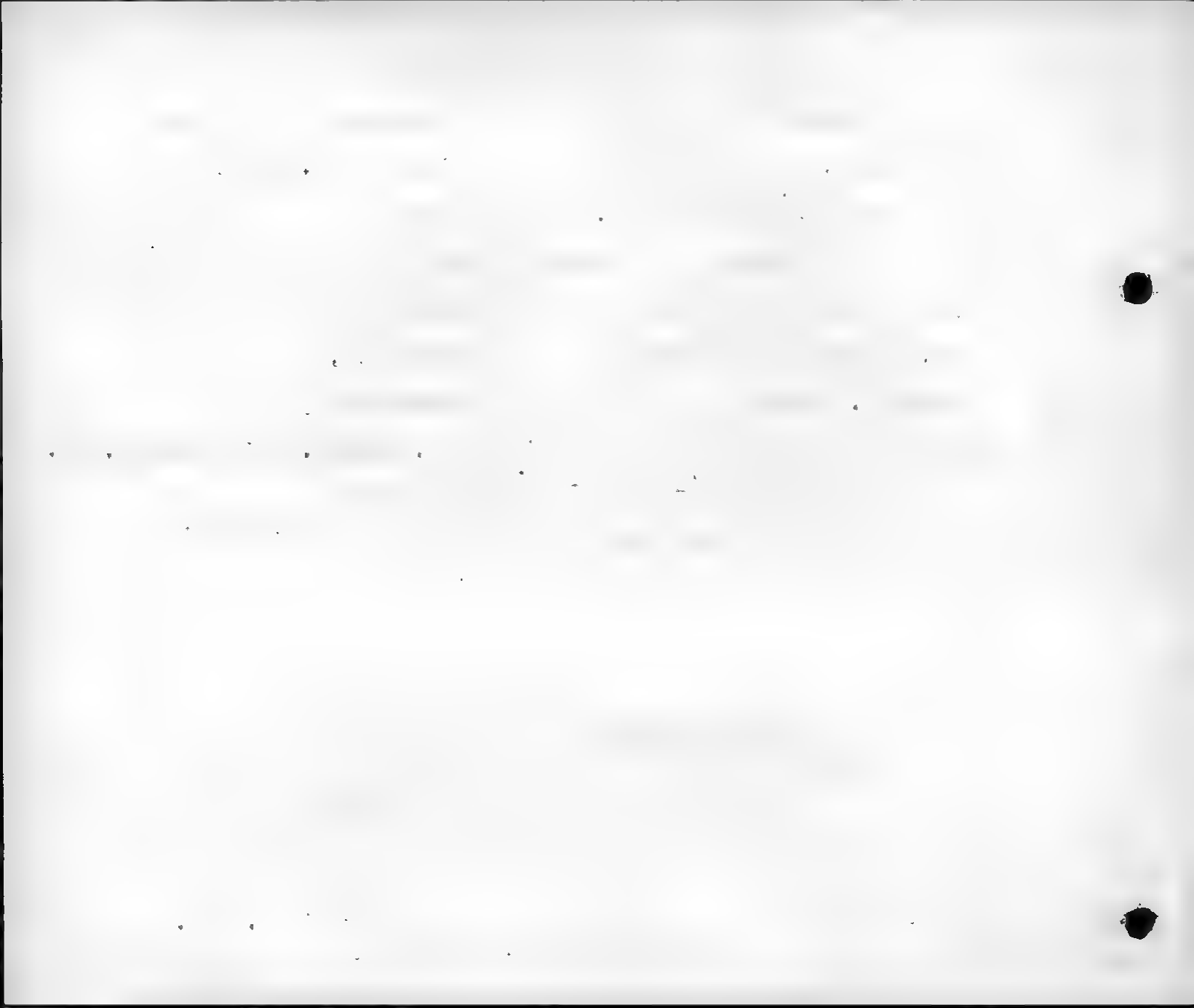
3504

CERTIFICATE OF DEATH

Reg. Dist. No.

03457

1. PLACE OF DEATH a. COUNTY <b>Gaithersburg</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived first institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montg</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rest Haven Rest Home,</b>		d. STREET ADDRESS <b>RFD #3</b>	
3. NAME OF DECEASED (Type or print) First <b>Turner</b> Middle <b>Jackson</b> Last <b>Foster</b>		4. DATE OF DEATH Month <b>Mar</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 18-1880</b>
9. AGE (in years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b></b> Min. <b></b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13. BIRTHPLACE (State or foreign country) <b>Limeton Va,</b>		14. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. FATHER'S NAME <b>Warner R. Foster</b>		16. MOTHER'S MAIDEN NAME <b>Martha Beam</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		18. SOCIAL SECURITY NO. <b></b>	
19. INFORMANT <b>William J. Foster, Gaithersburg, Md.</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure.</b> 31X DUE TO <b>Cerebral Vascular Accident</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Brain Hemorrhage)</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb</b> , 19 <b>60</b> , to <b>March 28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/28</b> , 19 <b>60</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Luciano I. Leal</b> M.D.		ADDRESS (Street, city or town, state) <b>Gaithersburg, Md</b>	
PHYSICIAN'S NAME (Type) <b>Luciano I. Leal M.D.</b>		DATE SIGNED <b></b>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/30/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Krause</b>		24. REC'D BY REGISTRAR <b>Arthur S. Krause</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		DATE <b>MAR 30 '60</b>	



3556

## CERTIFICATE OF DEATH

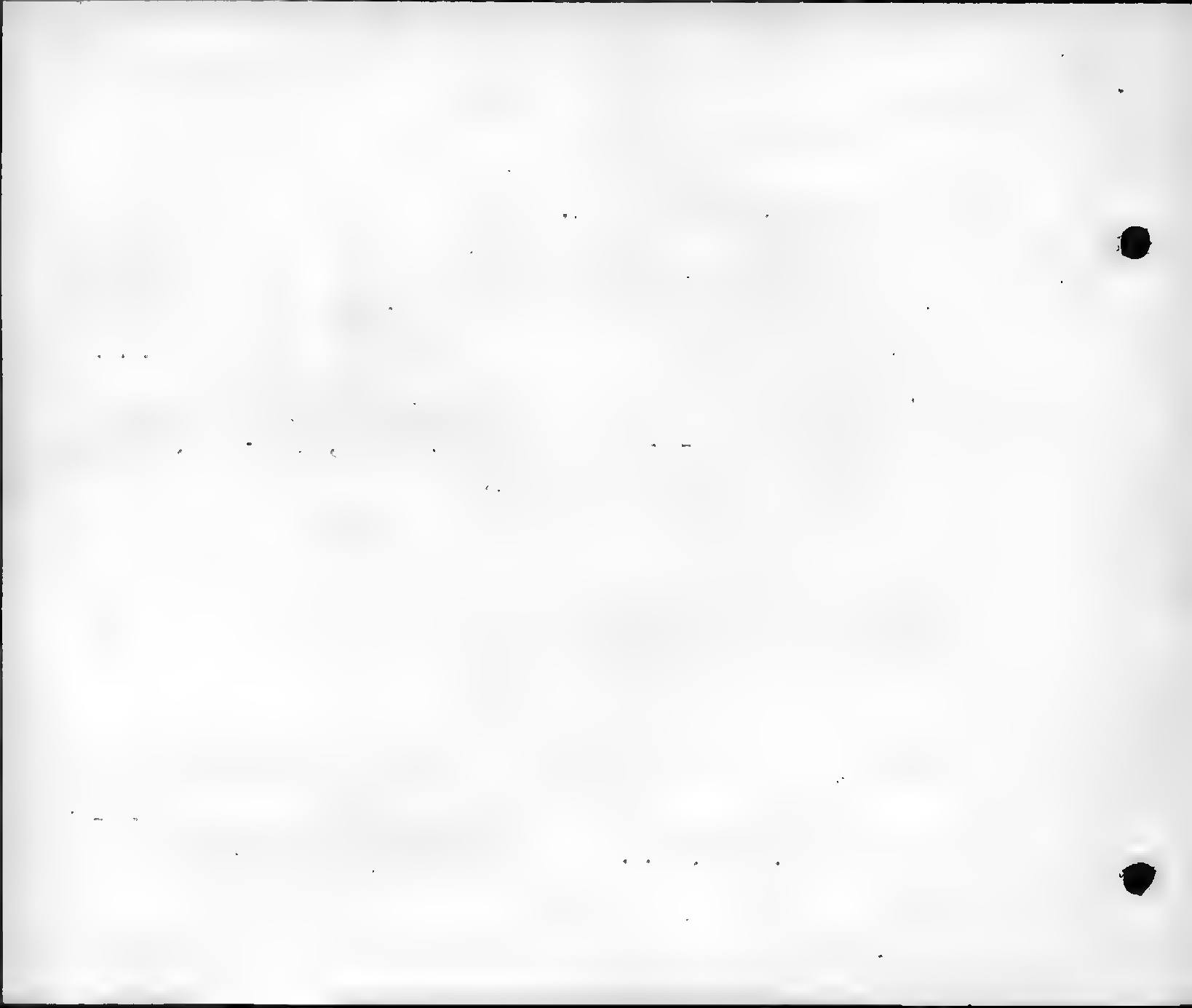
Reg. Dist. No.

03458

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Brownsville</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>144 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Faunell</b> Middle <b>Garaldene</b> Last <b>Fox</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 18, 1913</b>	
9. AGE (In years lost birthday) <b>46 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willis Oland</b>				14. MOTHER'S MAIDEN NAME <b>Eva James</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>316-26-2028</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>195.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Adrenal Cortical Carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>November 1, 1959</b> to <b>March 24, 1960</b> , that I last saw the deceased alive on <b>March 24, 1960</b> , and that death occurred at <b>6:50a</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>3-24-60</b>							
ACTUAL SIGNATURE <b>Gordon C. Sharp</b> M.D.				The Clinical Center			
PHYSICIAN'S NAME (Type) <b>GORDON C. SHARP, M.D.</b>				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Lebanon</b>		22d. LOCATION (City, town, or county) (State) <b>Warren County, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

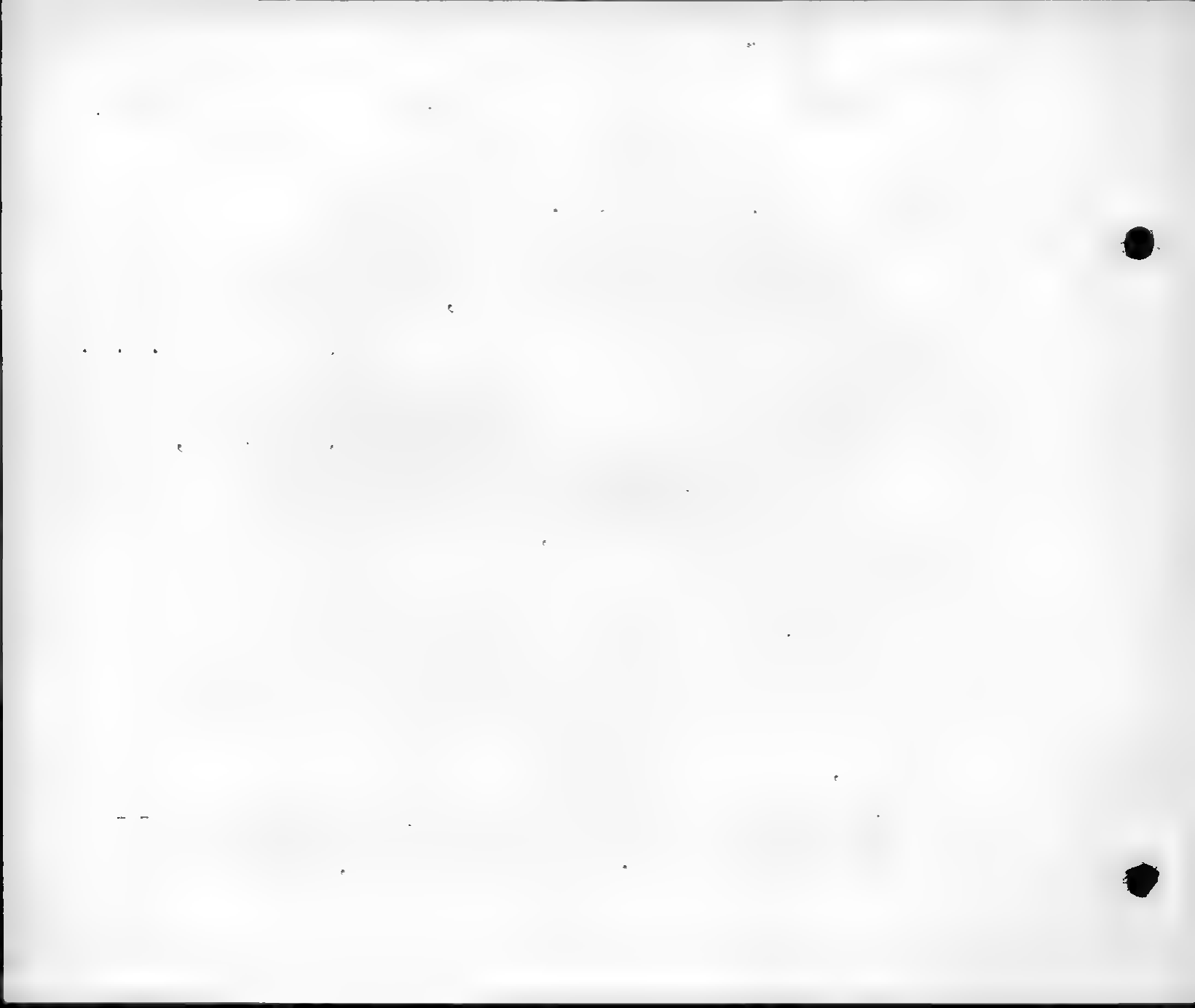
CERTIFICATE OF DEATH

03459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lynne</b> Middle <b>Beth</b> Last <b>Freedman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1960</b>			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1949</b>	
9 AGE (in years lost birthday) yrs. <b>10</b>		10. UNDER 1 YEAR Months <b>7</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11. UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Student)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
13. FATHER'S NAME <b>David Freedman</b>				14. MOTHER'S MAIDEN NAME <b>Irene Brownman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-Abdominal Hemorrhage from Metastases</b> DUE TO (b) <b>Adrenal Cortical Carcinoma with Metastases to Peritoneal Cavity, Liver and Lungs</b> DUE TO (c) <b>Peritoneal Cavity, Liver and Lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). <b>Severe Cachexia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 18, 1960</b> to <b>March 6, 1960</b> , that I last saw the deceased alive on <b>March 6, 1960</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-6-60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>							
22b. DATE THEREOF <b>MAR. 7, 1960</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>LLESAYETGRAD CEMETERY</b>							
22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS - 3501-14th St. N.W.</b>							
24a. REC'D BY REGISTRAR DATE <b>MAR 8 '60</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

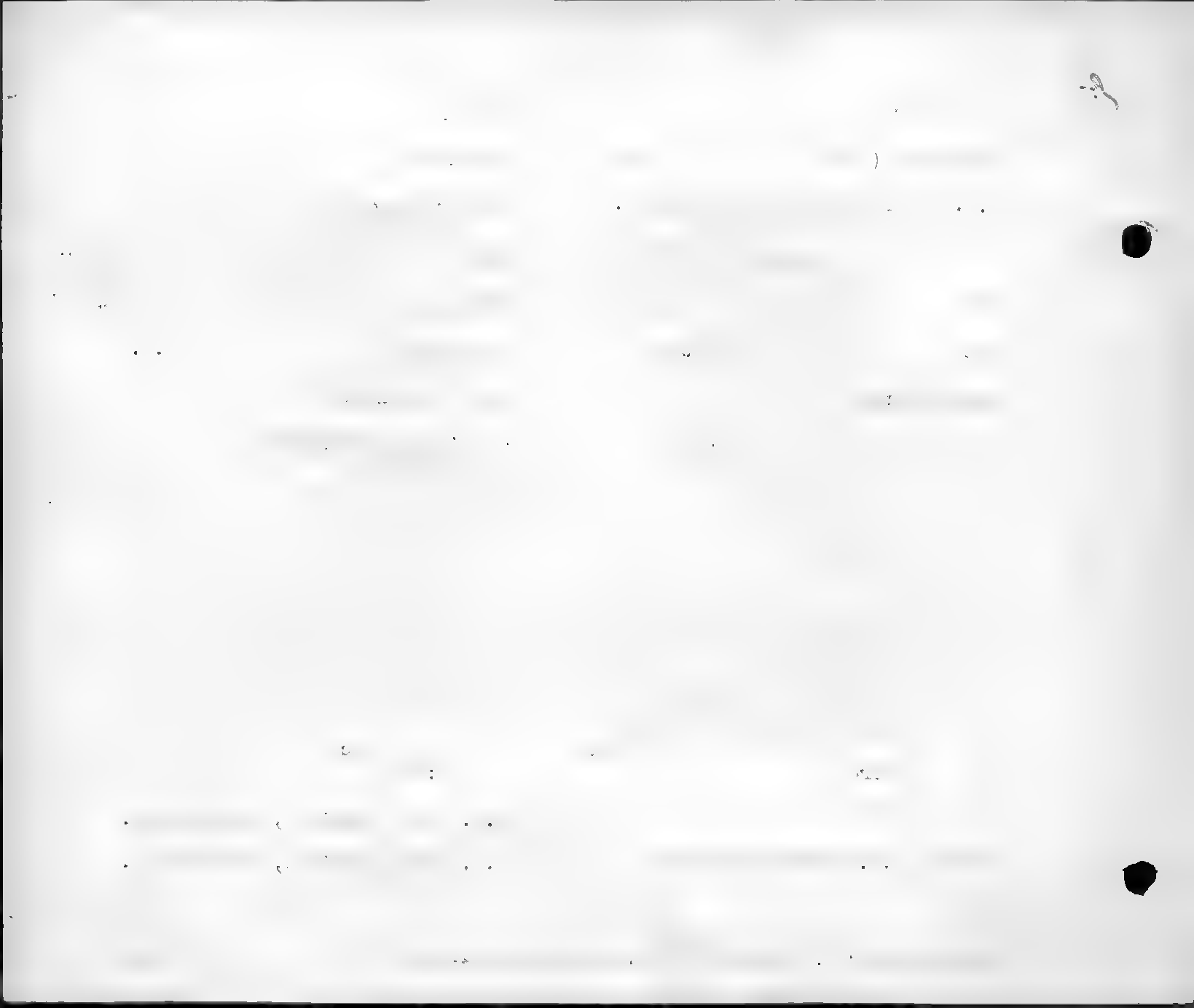
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## Reg. Dist. No. 215

**MEDICAL CERTIFICATION**

**DEPUTY FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03461

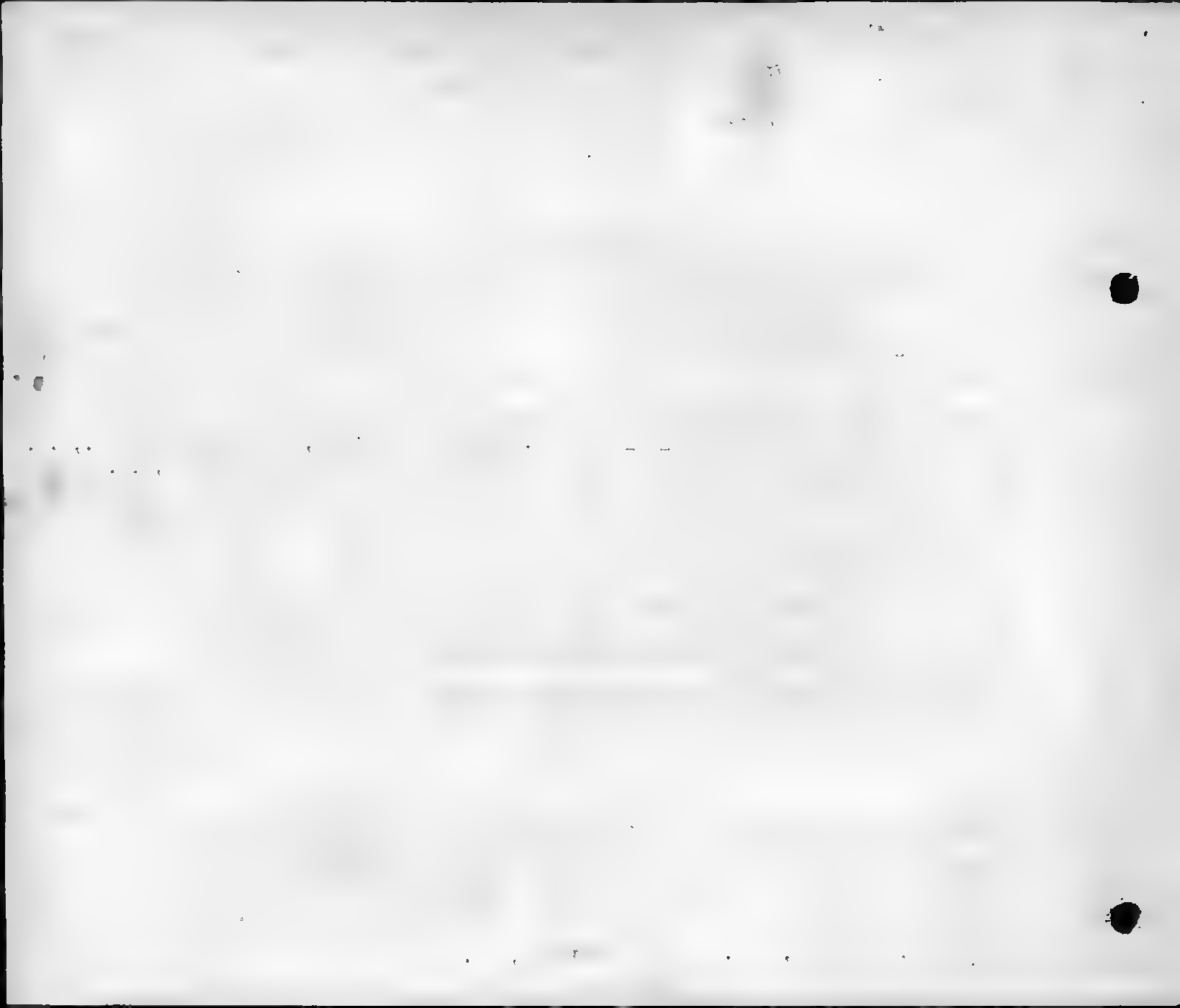
FOR STATE HEALTH DEPT.

Items 18&21 Film 250  
Item 7 Film G260

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before adm ss on) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>3 months</u>		d. STREET ADDRESS <u>8012 Flower Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8012 Flower Ave</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Last <u>William FRY</u> Also known as <u>FRY</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1916</u>
9. AGE (in years last birthday) <u>43</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Fabrication plant</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> # <u>2 WW</u>		16. SOCIAL SECURITY NO <u>269-18-3680</u>	
17. INFORMANT <u>Fry</u> Address <u>Mrs. Margaret Mae Fry, 734 Longfellow St., N.W. Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>post epileptic seizure - natural cause</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



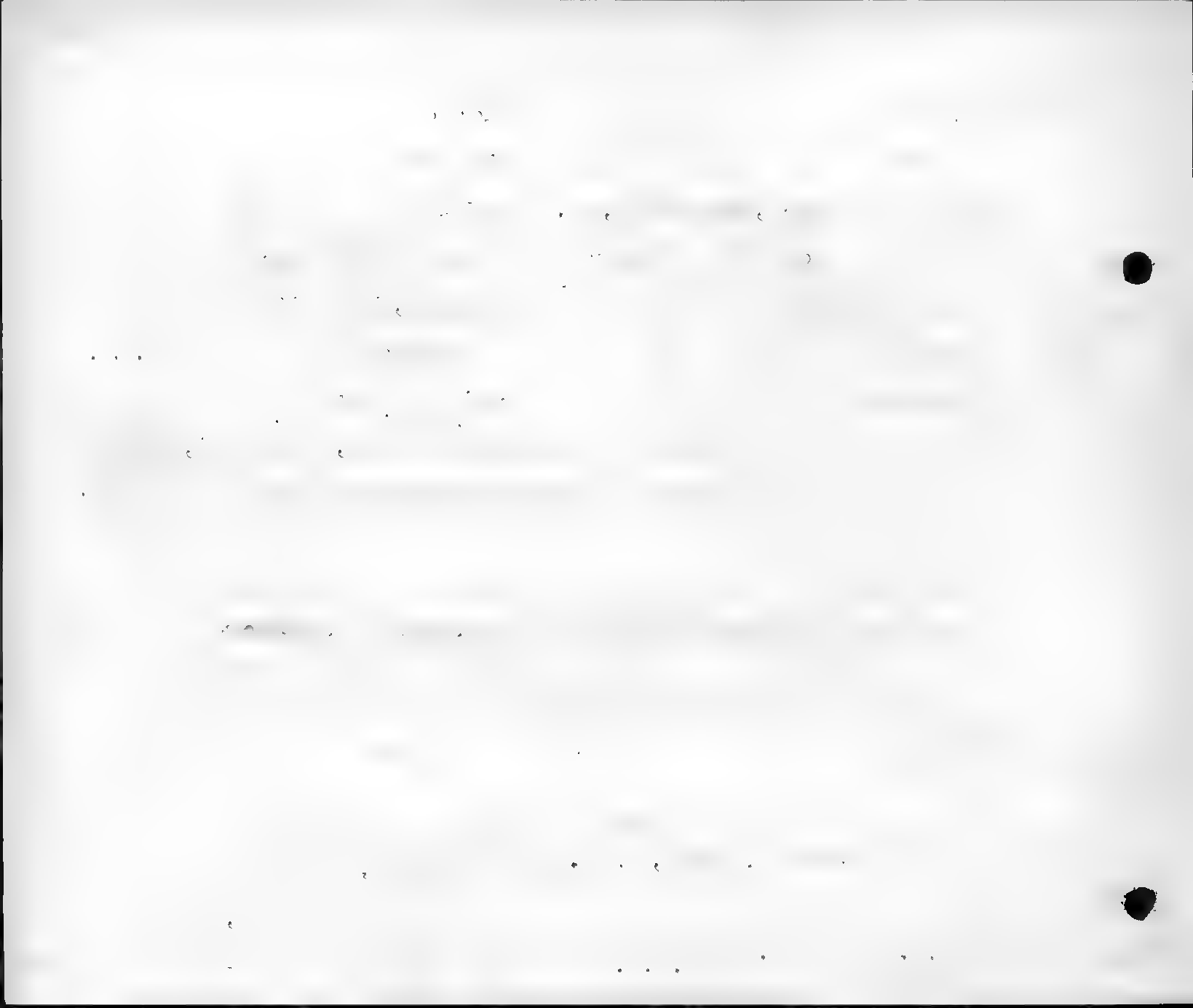
3559

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion) a. STATE <b>Colorado</b> b. COUNTY <b>Y</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Walsenburg</b> 443-3			
f. STREET ADDRESS <b>Box 142</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First <b>Joseph</b> Middle <b>Edward</b> Last <b>Garcia</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 1946</b>	9. AGE (In years lost birthday) <b>13</b> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silbino Garcia</b>				14. MOTHER'S MAIDEN NAME <b>Elvira Martinez</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metabolic acidosis due to unknown cause</b> 7856 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute lymphocytic leukemia with central nervous system involvement</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>February 25, 19 60</b> , to <b>March 2, 19 60</b> , that I last saw the deceased alive on <b>March 2, 19 60</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>		M.D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state) <b>National Institutes of Health Bethesda 14, Maryland</b>		DATE SIGNED <b>3/2/60</b>	
PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>	
22d. LOCATION (City, town, or county) (State) <b>Walsenburg, Colorado</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St., N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.





3560

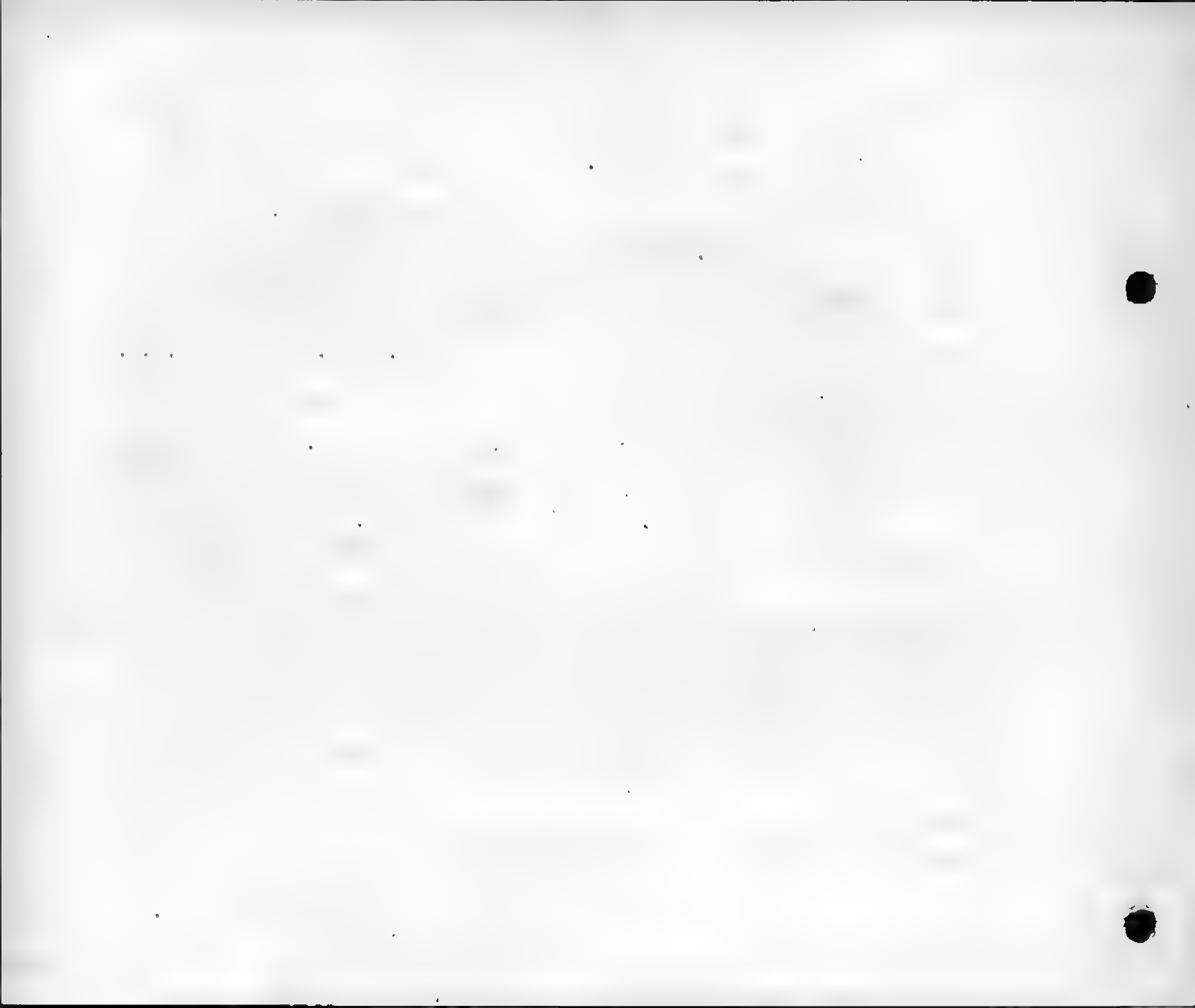
CERTIFICATE OF DEATH

03463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna D.</u> Middle <u>Gary</u> Last <u></u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/79</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dyre</u>		14. MOTHER'S MAIDEN NAME <u>Millicent Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-20-6483</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral stenosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/31/1958</u> to <u>March 30 1960</u> , that I last saw the deceased alive on <u>March 29 1960</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10511 Seawood Ave</u> DATE SIGNED <u>3/30/60</u> ACTUAL SIGNATURE <u>George Sharpe</u> M.D. <u>Kensington Md</u> PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			
22a. BURIAL, CREMATATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hines</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



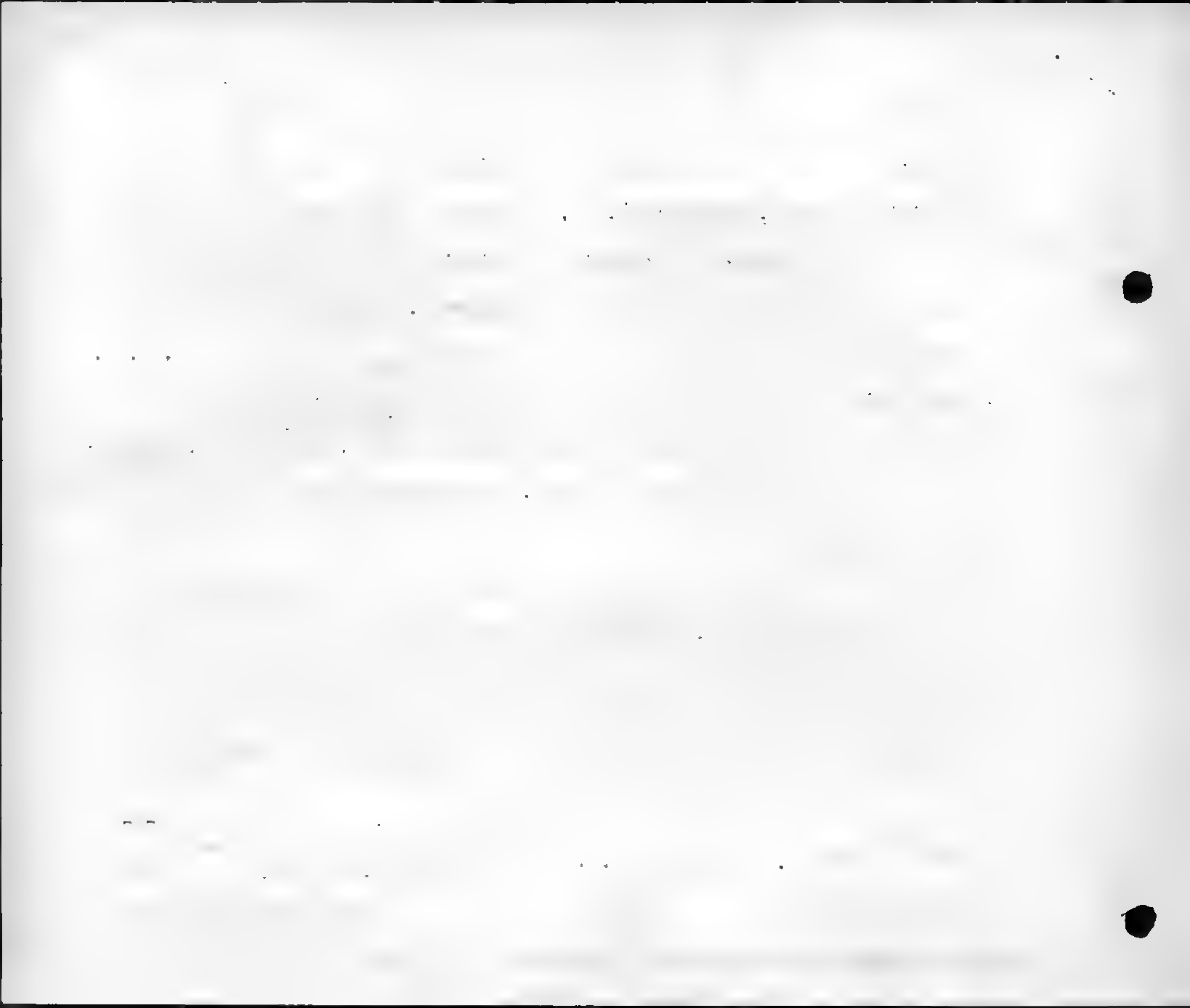
3561

## CERTIFICATE OF DEATH

03464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>222 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Clifton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clifton</b> d. STREET ADDRESS <b>38 Mayflower Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Angela Catherine Gottlieb</b>		4. DATE OF DEATH Month Day Year <b>March 7 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 2, 1890</b>
9. AGE (In years lost birthday) <b>69 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Bunino</b>		14. MOTHER'S MAIDEN NAME <b>Ursula Magenetto</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thyroid Carcinoma, Metastatic to Lungs</b> <b>194X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Diabetes Mellitus, Purulent Tracheobronchitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29</b> , 19 <b>59</b> , to <b>March 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 7</b> , 19 <b>60</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 3-7-60</b> <b>National Institutes of Health Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>John W. Singleton M.D.</b>		M.D. <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. SINGLETON, M.D.</b>		<b>National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-trans.</b>	22b. DATE THEREOF <b>3/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	22d. LOCATION (City, town, or county) (State) <b>Patterson New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 10 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Charles L. Hume</i>	

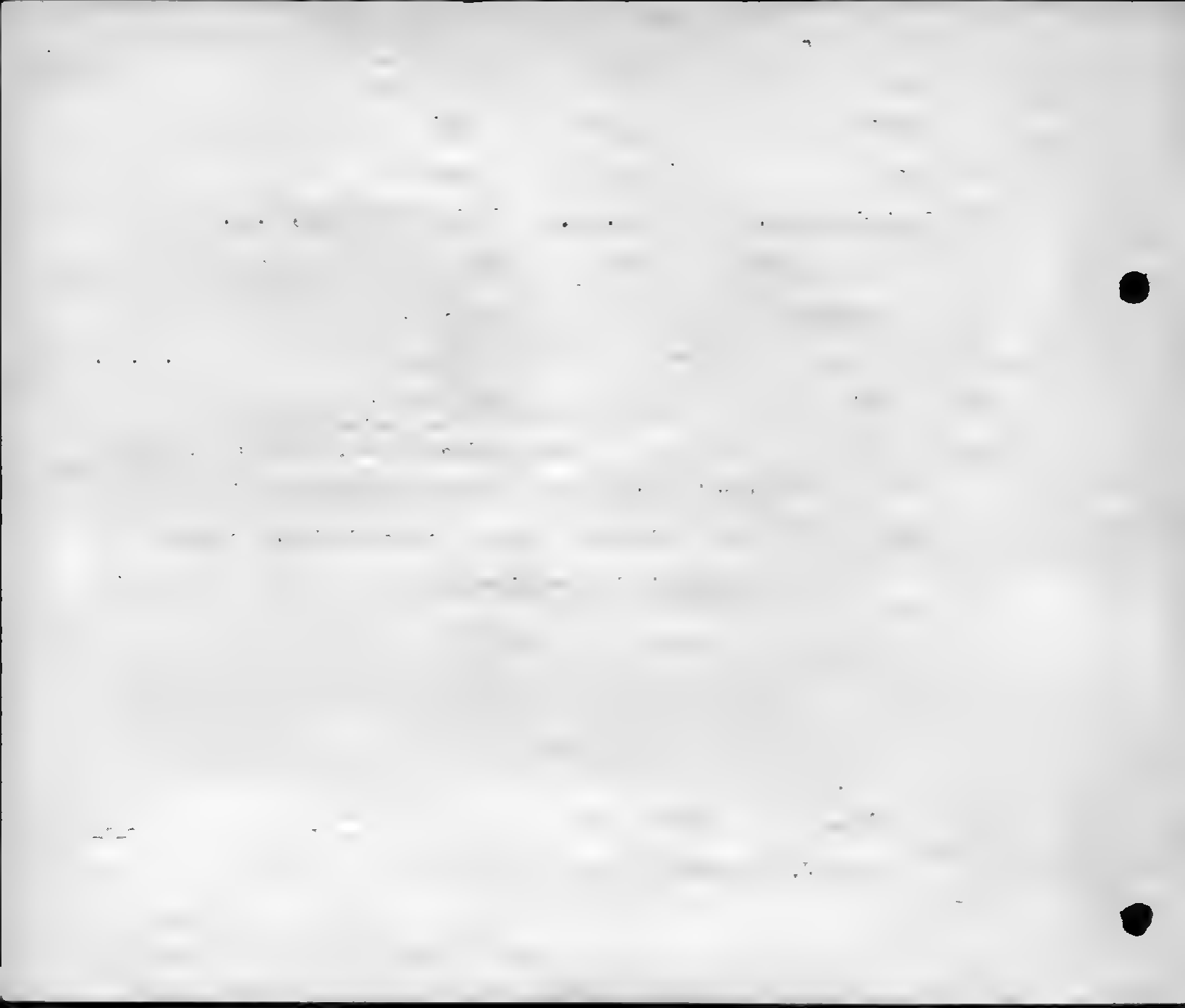


**MARYLAND STATE DEPARTMENT OF HEALTH  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03465

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b> d. NAME OF DECEASED (Type or print) <b>Robert Grant</b> e. SEX <b>Male</b> f. COLOR OR RACE <b>Negro</b> g. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b> h. FATHER'S NAME <b>Robert Grant</b> i. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b> j. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest due to nitrous oxide anesthesia</b> 754.2 CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b) <b>Ventricular septal defect and aortic insufficiency</b> (c) <b>Congenital heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. EXAMINER'S NAME (Type) <b>Frank J. Broschart</b> 22a. BURIAL, CREMATION REMOVAL (Specify) 22b. DATE THEREOF <b>3-3-60</b> 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) <b>Atlanta Georgia</b> 23. FUNERAL DIRECTOR ADDRESS <b>Francis's Funeral Home, Inc., 389 R.D. Ave. N.W.</b> 24a. REC'D BY REGISTRAR <b>DAMAR 3 '60</b> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Atlanta</b> c. STREET ADDRESS <b>1503 Moury Avenue, S. E.</b> d. DATE OF DEATH <b>March 1 1960</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>4</b> yr. Months Days Hours M.n. g. BIRTHPLACE (State or foreign country) <b>Georgia</b> h. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> i. MOTHER'S MAIDEN NAME <b>Emma Cooper</b> j. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b> k. INTERVAL BETWEEN ONSET AND DEATH <b>Life</b> l. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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TO BE retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
15M 9/59

March 4/5/60

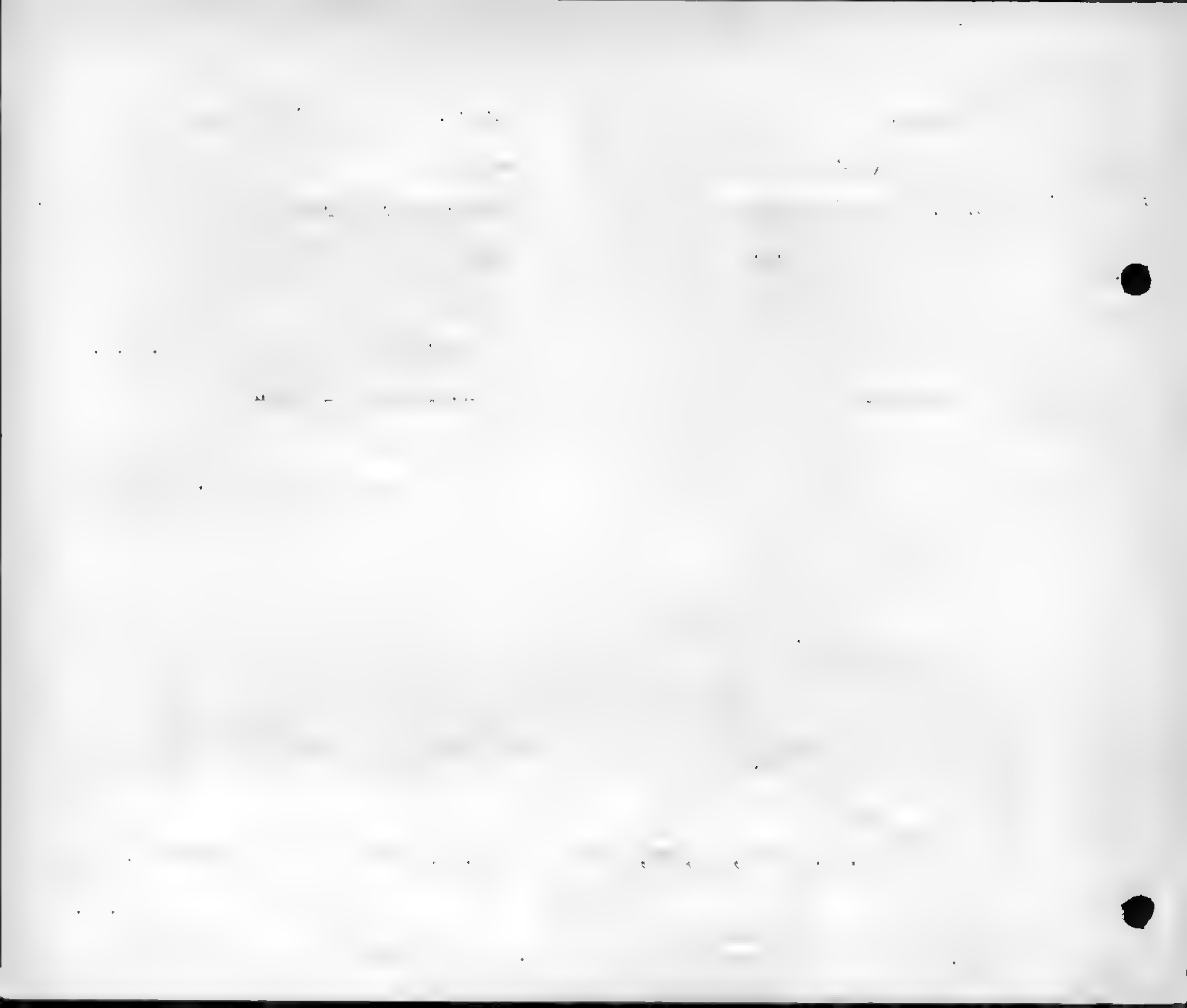
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03466

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>9602 Wadsworth Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ann</b> Last <b>GRANT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-22-60</b>	
9. AGE (in years last birthday) <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min <b>4</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert GRANT</b>				14. MOTHER'S MAIDEN NAME <b>Ann Yvonne BRIETBACH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia and meningitis in newborn organism,</b> DUE TO (b) <b>unknown at present</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>unknown at present</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Richard</b> attended the deceased from <b>March 22, 1960</b> , to <b>March 26, 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>March 26, 1960</b> , and that death occurred at <b>1025A</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>G. B. Avery</b>				22b. DATE SIGNED <b>3-26-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-29-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneal</b>	

1-06XVS





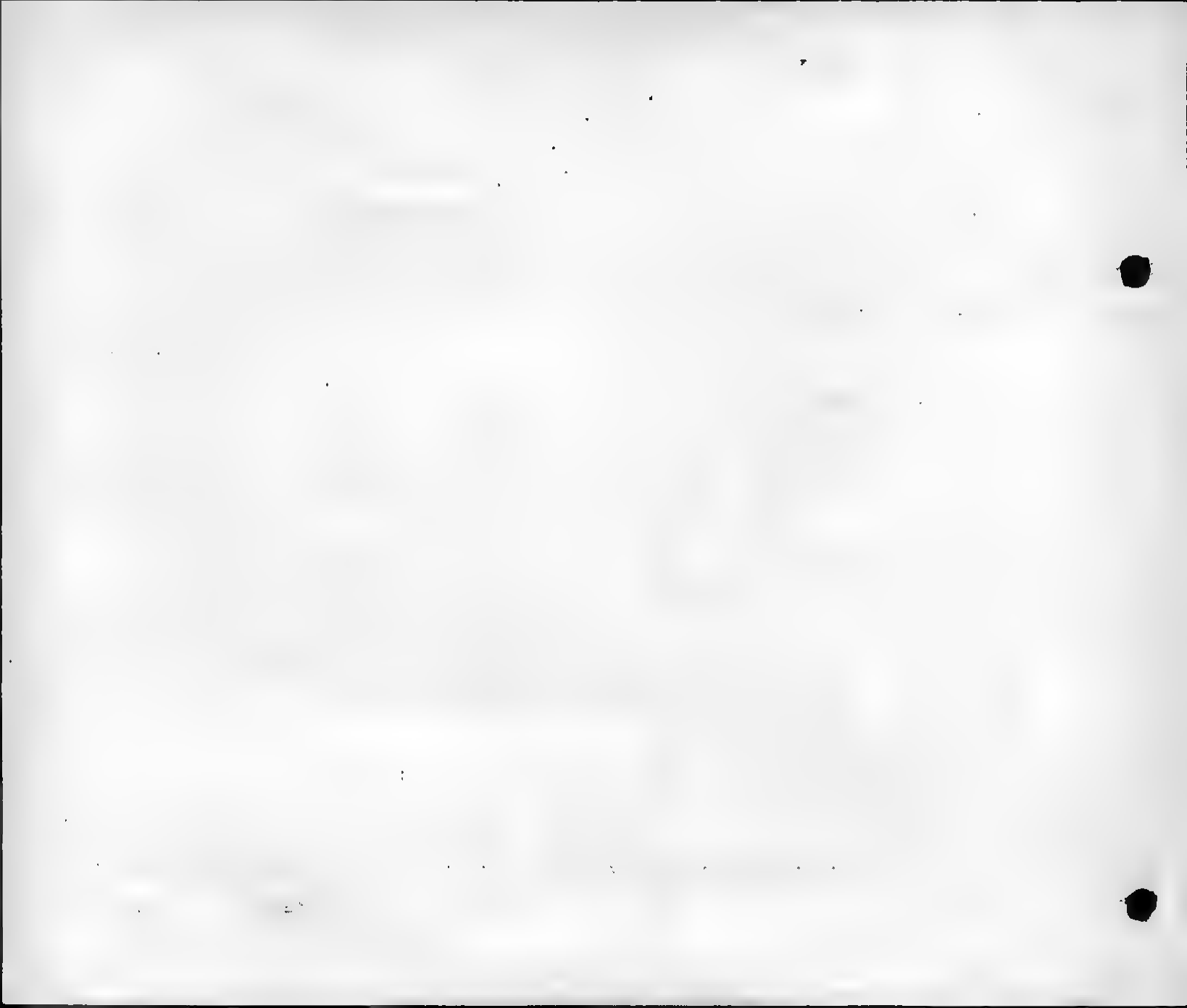
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3504

03467

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>3 hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>5318 Belt Road, N. W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Alvin</b> Middle <b>Ray</b> Last <b>GREER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-22-60</b>	
9. AGE (In years lost birthday) <b>3 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilburn H. GREER</b>				14. MOTHER'S MAIDEN NAME <b>Audrey Louise</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal: Asphyxia</b> <b>76</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>March 22, 1960</b> to <b>March 22, 1960</b> that (I) <b>did</b> last saw the deceased alive on <b>March 22, 1960</b> , and that death occurred at <b>7:50 P.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>F. W. Grello</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3-23-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. W. GRELLO, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-24-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				25a. REGISTRY REGISTER <b>MAR 28 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Conrad S. Threlk</b>	

2051181XV1



TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

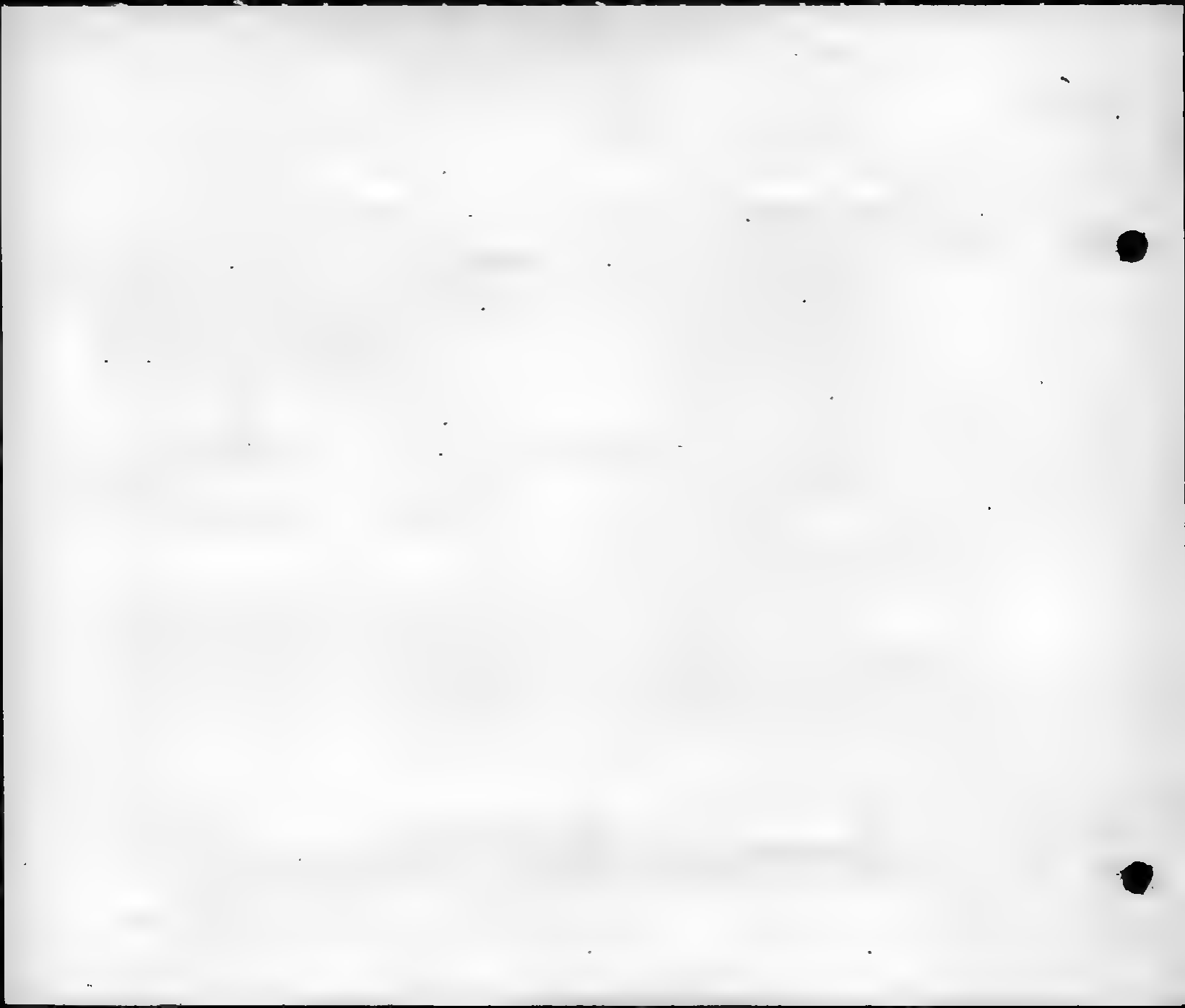
VR A15 (4)  
ISM 9/59

3565

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03468

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5415 Bradley Blvd.</b>		d. STREET ADDRESS <b>9918 Juliard Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>S.</b> Last <b>GREGORY</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>9,</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 16, 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Loman S. Stalnaker</b>		14. MOTHER'S MAIDEN NAME <b>Alice Shahan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>	
17. INFORMANT <b>Husband</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 422.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Congestive heart failure</b> DUE TO (c) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Mar 9 1960</b>		20d. INJURY OCCURRED <b>While at work</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 15 1960</b> to <b>Mar 9 1960</b> that (I) (we) last saw the deceased alive on <b>March 9 1960</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert G. Brewer</b>		22b. DATE SIGNED <b>3/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. BREWER M.D.</b>		22d. ADDRESS <b>8218 WISCONSIN AVE BETHESDA MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/14/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Parsons, West Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	
ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 11 '60</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

3500  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03469

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ilkley</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>	
f. STREET ADDRESS <u>105 Brown Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hammond</u> Last <u>Grimes</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/23/02</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Basil Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ida Tasker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>214-01-5834</u>	
17. INFORMANT <u>HA</u> Address <u>Hospital Records, Ilkley, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>203X</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 21, 1959</u> to <u>Mar. 27, 1960</u> that (I) (we) last saw the deceased alive on <u>Mar. 29, 1960</u> and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above	
22a. SIGNATURE <u>Jack Schumacher</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		22d. ADDRESS <u>Gaithersburg Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth.</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonsville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 4 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

1. ~~FOR-STATE~~  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Travilah Rd</u>				d. STREET ADDRESS <u>Travilah Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Chas. Angela Grimes</u>				4. DATE OF DEATH <u>Mar 25 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-5-1898</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Angela Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes-Unkn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to</u> DUE TO (c) <u>due to</u>				17. INFORMANT <u>Arthur Grimes (brother)</u> Address <u>Stem 2</u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in yard near home</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/28/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem</u>				22d. LOCATION (City, town, or country) (State) <u>Darnestown, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 30 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

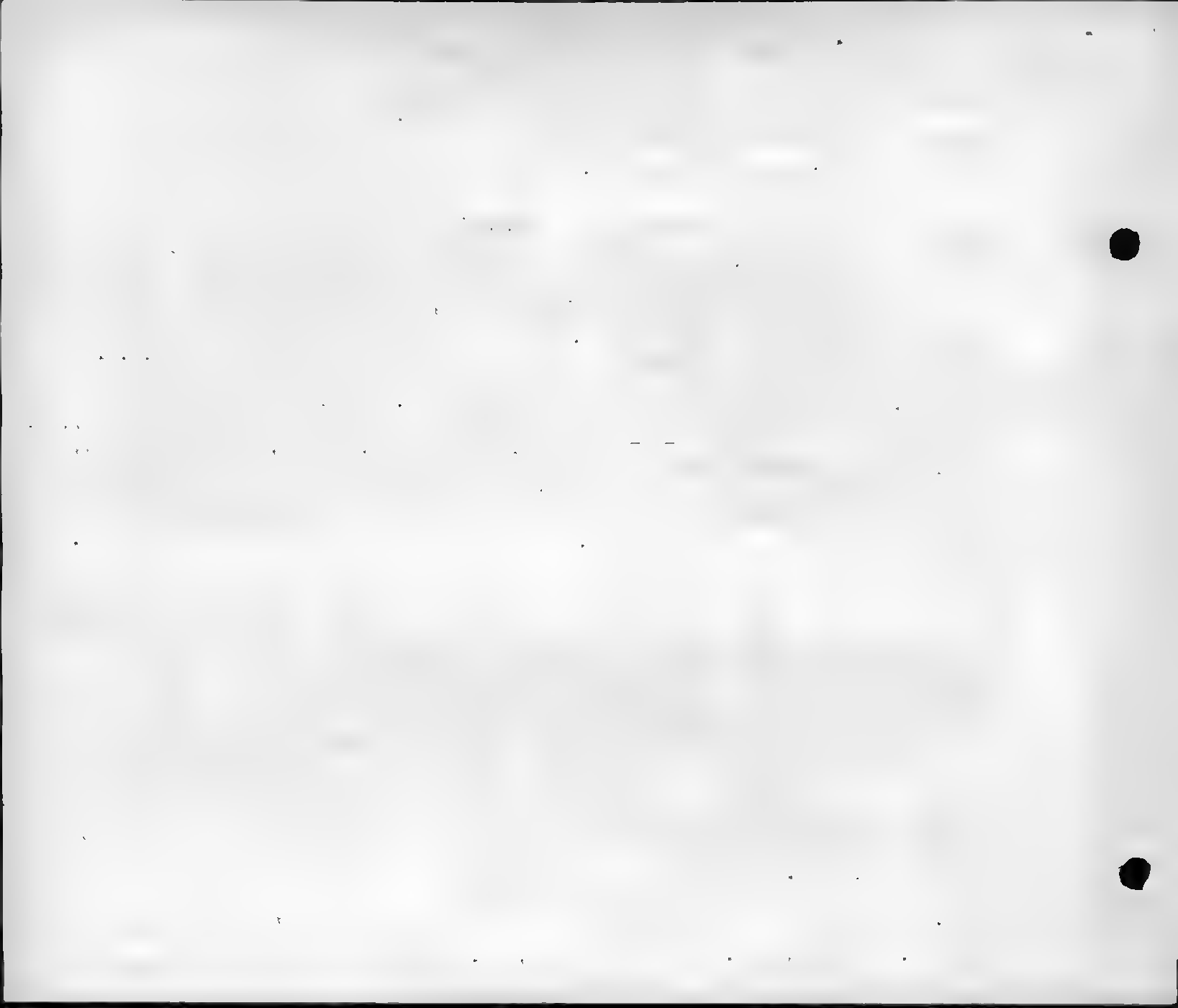
3438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admit on) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>150 Bonifant Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>150 Bonifant Road</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle <b>LOTTIE LEE</b> <b>GRUSSNER</b>		4. DATE OF DEATH Month Day Year <b>MARCH 12 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1897</b>
9. AGE (In years, month & day) <b>62 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done, including life, even if retired) <b>SALES LADY</b> <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>THE HECHT CO.</b> <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES E. BARROW</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE W. CLEMENT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>579-40-3239</b>	
17. INFORMANT <b>MRS. KATHERINE E. LUKENS</b>		Address <b>SILVER SPRING, MD.</b> <b>150 BONIFANT RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>42-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed</b> <b>yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/12/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/15/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FOREST LAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>RICHMOND, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PIMPHREY, INC.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

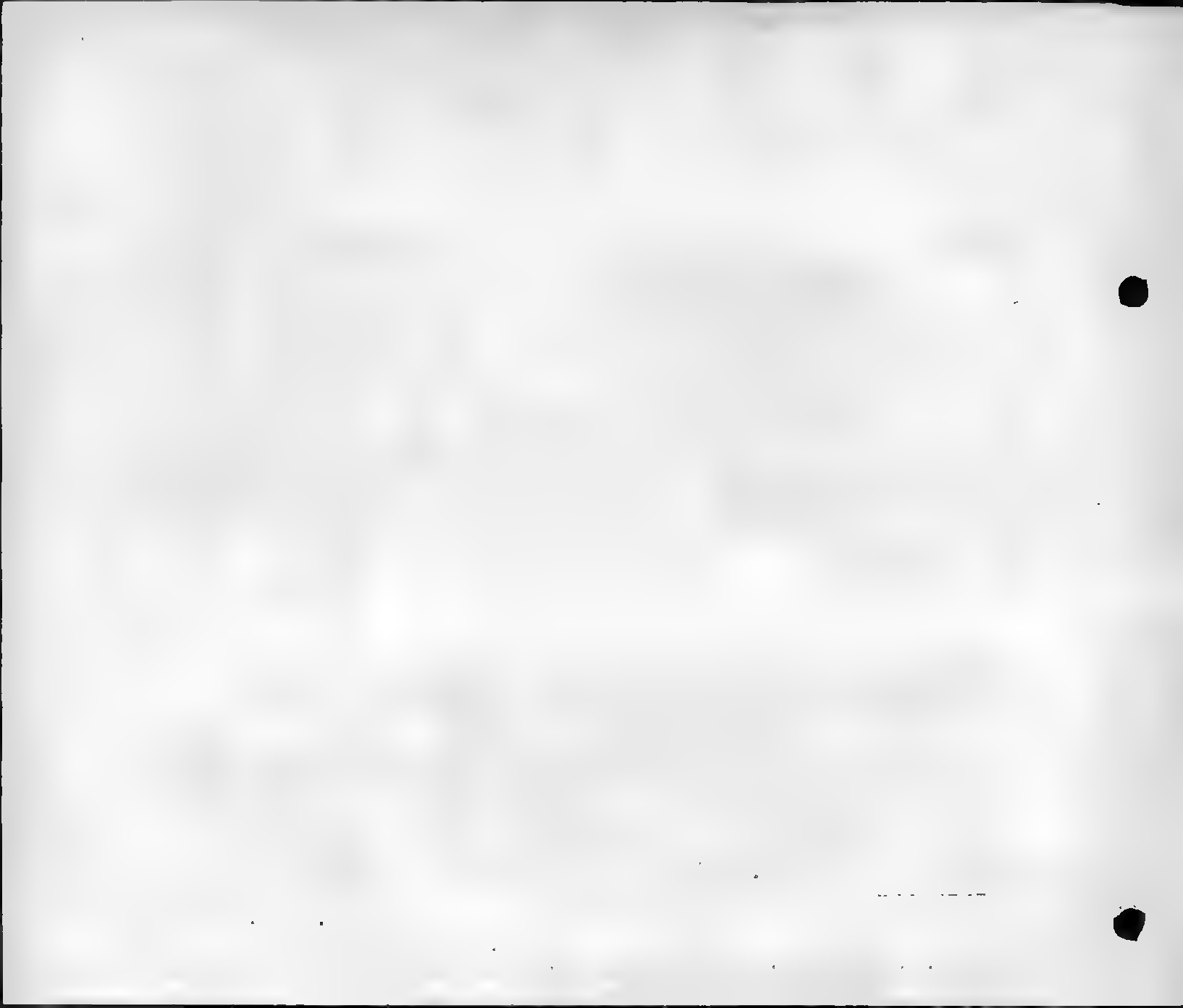
VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03472

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>	
		f. STREET ADDRESS <u>16 Eastmore Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Josephine Agnes Haas</u>		4. DATE OF DEATH <u>March 18 1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Paul, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Zahn</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Kathryn Diekel</u>		Address <u>6 Eastmore Drive, S. Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid carcinoma of bladder</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Hilbert S. Sabin</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Hilbert S. Sabin</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>3/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Paul, Minnesota</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>Wash, DC</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hines</u>
		DATE <u>MAR 21 '60</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G260 4/11/60 1b

350

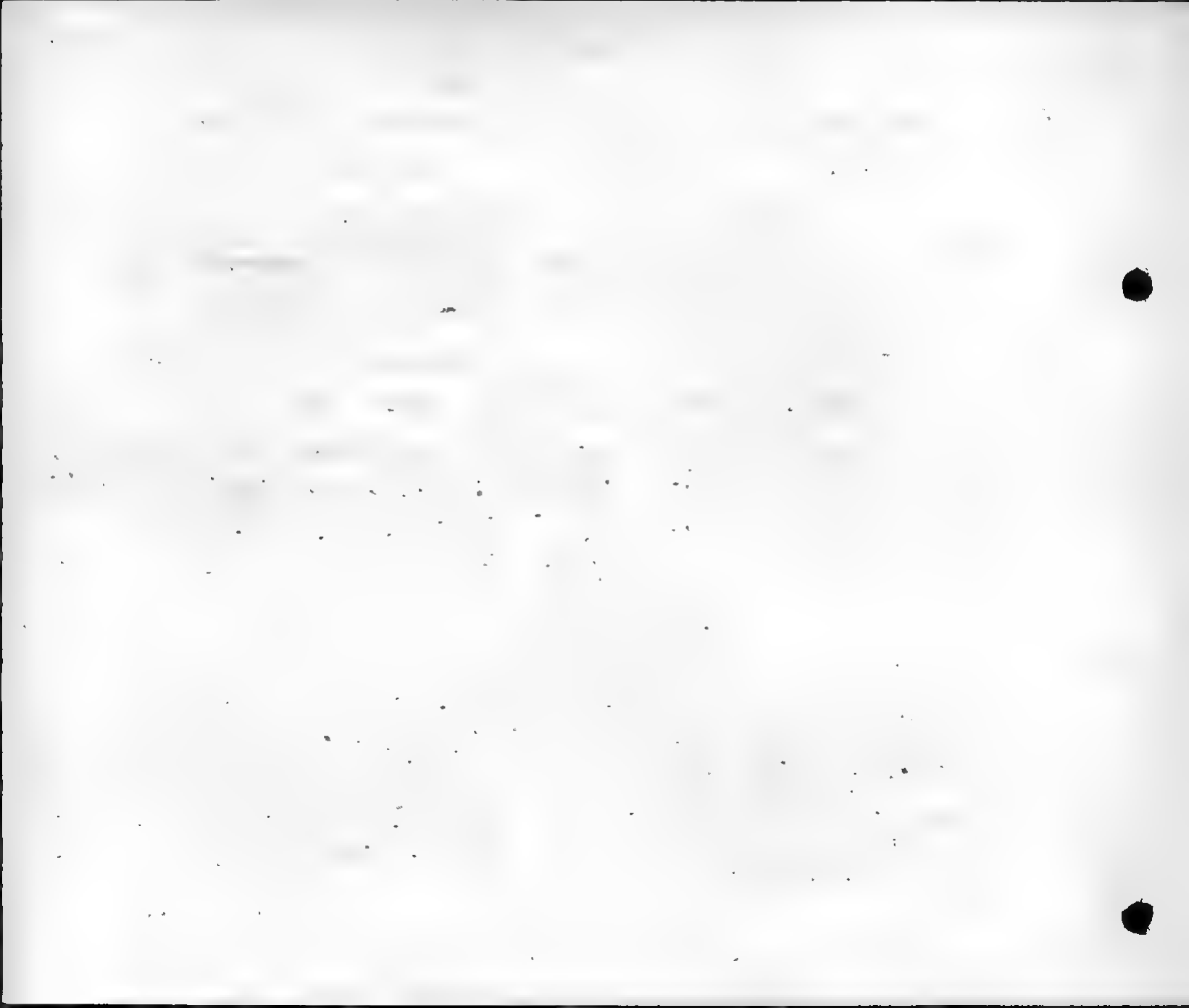
## CERTIFICATE OF DEATH

Reg. Dist. No.

03473

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <b>25 Hrs.</b> c. LENGTH OF STAY IN lb <u>58</u> <b>Chevy Chase</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u> <b>111 Graffton St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>Hardesty</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>29</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 28, 1880</u>	
<b>9. AGE</b> (In years last birth day) <u>79</u> yrs		<b>10. AGE</b> (In years last birth day) <u>79</u> yrs		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Engineer</u>			
<b>13. FATHER'S NAME</b> <u>Richard Henry De Groat Hardesty</u>				<b>14. MOTHER'S M maiden name</b> <u>Frances Dix</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>Army</b>				<b>16. SOCIAL SECURITY NO</b> <u>Wife Elsie L. Hardesty</u> <b>Same as Above</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost				INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month <u>Mar</u> Day <u>29</u> Year <u>1960</u> Hour <u>9</u> p. m.				<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>Mar 28, 1960</u> <b>to</b> <u>Mar 29, 1960</u> <b>that I last saw the deceased</b> <u>olive</u> <b>on</b> <u>Mar 29, 1960</u> <b>and that death occurred at</b> <u>2203</u> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <u>A. H. Richwine</u> <b>M.D.</b>				<b>ADDRESS</b> (Street, city or town, state) <u>5522 Chesapeake Ave, Chevy Chase 15, Md.</u> <b>DATE SIGNED</b> <u>29 Mar 1960</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>A. H. Richwine</u>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>4/1/60</u>			
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Hill Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Berryville, Virginia.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Enders</u> <b>ADDRESS</b> <u>Berryville, Va.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>APR 4 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 be retained by the hospital or attending physician.  
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6, Film 02-333,076

3472

## CERTIFICATE OF DEATH

Reg. Dist. No.

03474

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>24 HRS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SAN. &amp; HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALDELPHI</u> d. STREET ADDRESS <u>2212 PHELPS RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> First Middle Last <u>ALEXANDER STEPHEN HARDY</u> (Type or print)				<b>4. DATE OF DEATH</b> Month Day Year <u>3 18 1960</u>			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-11-59</u>			
<b>9. AGE</b> (In years last birthday) <u>9 months</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>STEPHEN C. HARDY</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>SUSANNE ROBINSON</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>none</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>			
<b>17. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory infection</u> <u>754.5</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>complicated heart disease</u> DUE TO (c)				<b>INTERVA. BETWEEN ONSET AND DEATH</b> <u>12 hr</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I attended the deceased from</b> <u>3/17/60</u> , 19 <u>60</u> , <b>to</b> <u>3/18</u> , 19 <u>60</u> <b>that I last saw the deceased alive on</b> <u>19</u> , <b>and that death occurred at</b> <u>M</u> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <u>Silver Spring, Md</u> <b>DATE SIGNED</b>							
<b>ACTUAL SIGNATURE</b> <u>Marvin Mones</u> <b>M.D.</b>							
<b>PHYSICIAN'S NAME (Type)</b> <u>MARVIN MONES</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>TRANS. &amp; BURIAL</u>		<b>22b. DATE THEREOF</b> <u>3/20/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Back Creek Associate Reform Presbyterian Church Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>CHARLOTTE, N.C.</u>		<b>(State)</b>		<b>24a. REC'D BY REGISTRAR</b> <u>MAR 21 '60</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WALKER E. PUMPHREY, INC.</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			

Page 4

24 hours after death.

Certificate be executed

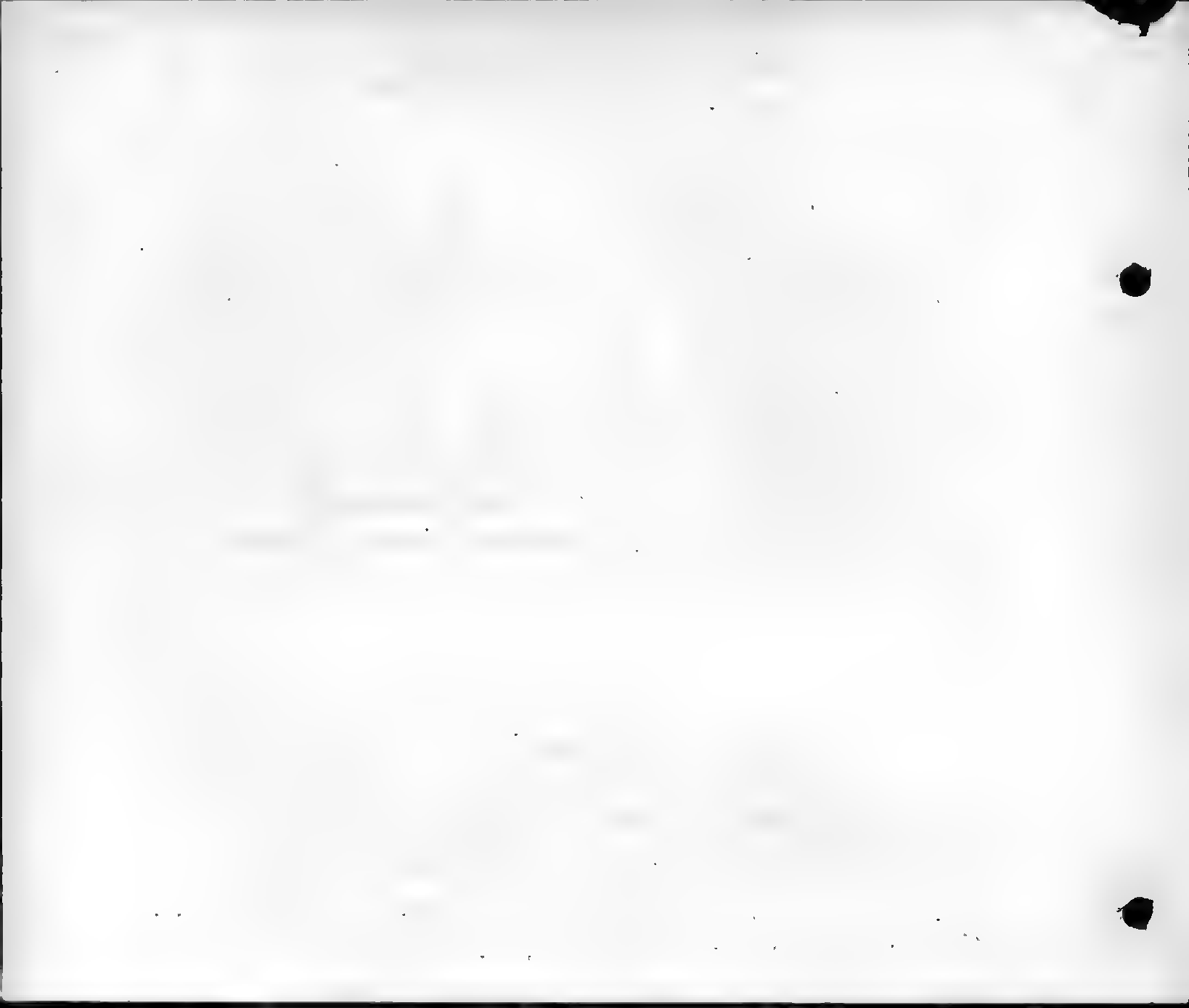
by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)

15M 9/58





TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

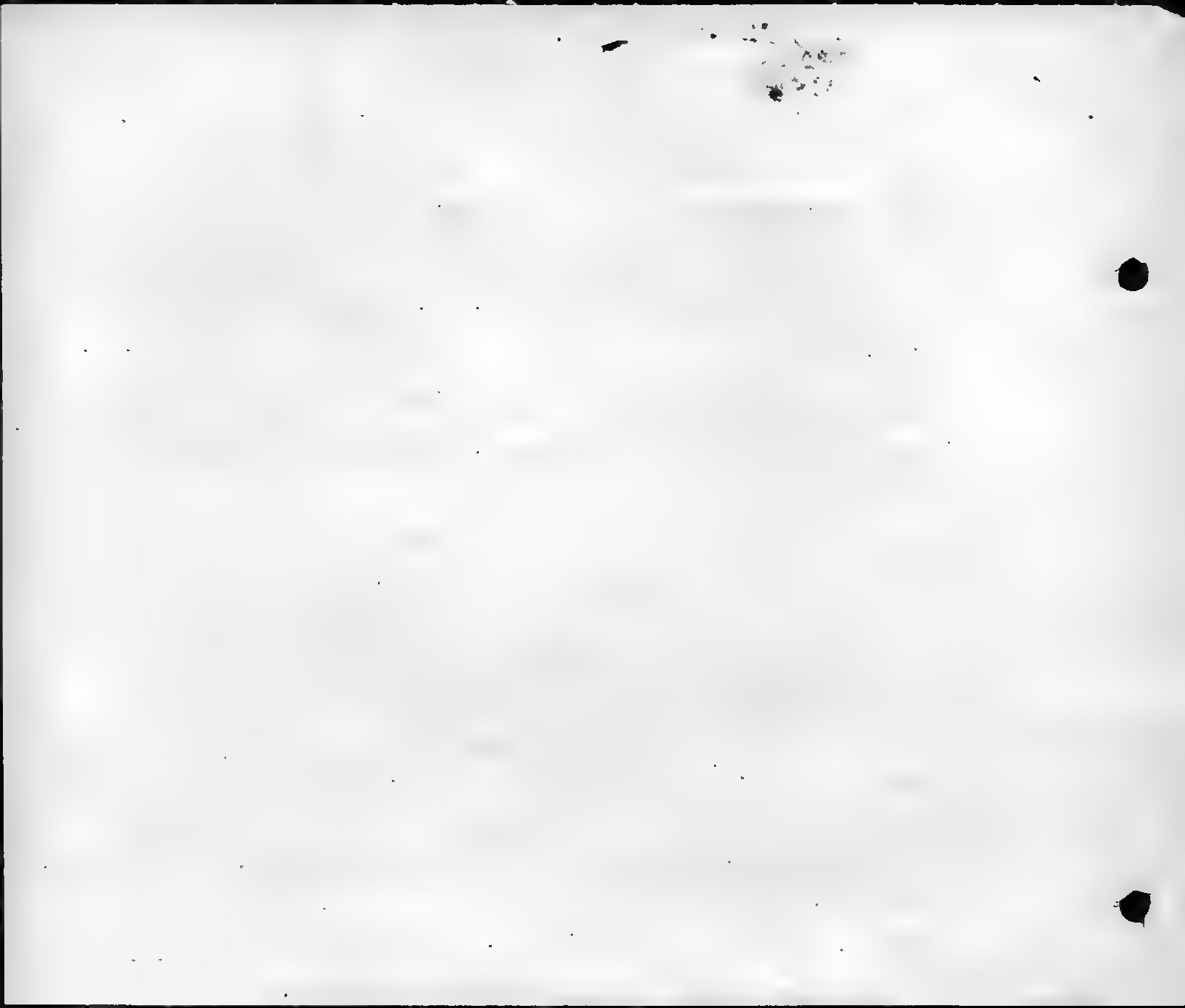
3568

## CERTIFICATE OF DEATH

03475

Item 2 C & D, Film 0260 4/12/60 iwh

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b> c. LENGTH OF STAY IN 1b <b>2½ Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac Burtonsville, Md.-with neice</b> d. STREET ADDRESS & h-r husband, both <b>Ropine Nursing Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>FRANKLIN</b> Last <b>HAYWARD</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1895</b> 9. AGE (In years last birthday) <b>64</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William H. Hayward</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hampton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>James H. Hayward</b>	
17. INFORMANT <b>Son</b>		18. ADDRESS <b>5506 High Ridge St. Arbutus, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>heart failure</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Accident</b> DUE TO (c) <b>Cerebral Embolism</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1959</b> , to <b>Mar 24, 1960</b> that (I) <b>had</b> last saw the deceased alive on <b>Mar. 24, 1960</b> , and that death occurred at <b>3P.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>William H. Killay</b>		22b. DATE SIGNED <b>3-28-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM H. KILLAY</b>		22d. ADDRESS <b>9902 Counselman Rd., Potomac, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<b>Burial-transit</b>	<b>3-28-60</b>	<b>Riverview Cemetery</b>	<b>Richmond, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b> DATE <b>APR 4 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Curtis S. Thomas</b>	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03476

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>35 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. STREET ADDRESS <b>4505 Chase Avenue</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Albert</b> Middle <b>Virgil</b> Last <b>HEADLEY</b>		4. DATE OF DEATH		Month <b>March</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-02</b>	9. AGE (in years last birthday) <b>57</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert N. HEADLEY</b>				14. MOTHER'S MAIDEN NAME <b>Bertha STARR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-28-4289</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, Brain</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Adeno Carcinoma, Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>physician</b> attended the deceased from <b>February 17, 19 60</b> to <b>March 23, 19 60</b> , that (I) <b>yes</b> last saw the deceased alive on <b>March 23, 1960</b> , and that death occurred at <b>10:35 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. S. IRONS, LT, MC, USN</b>		22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>H. S. IRONS, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>		ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



3570-

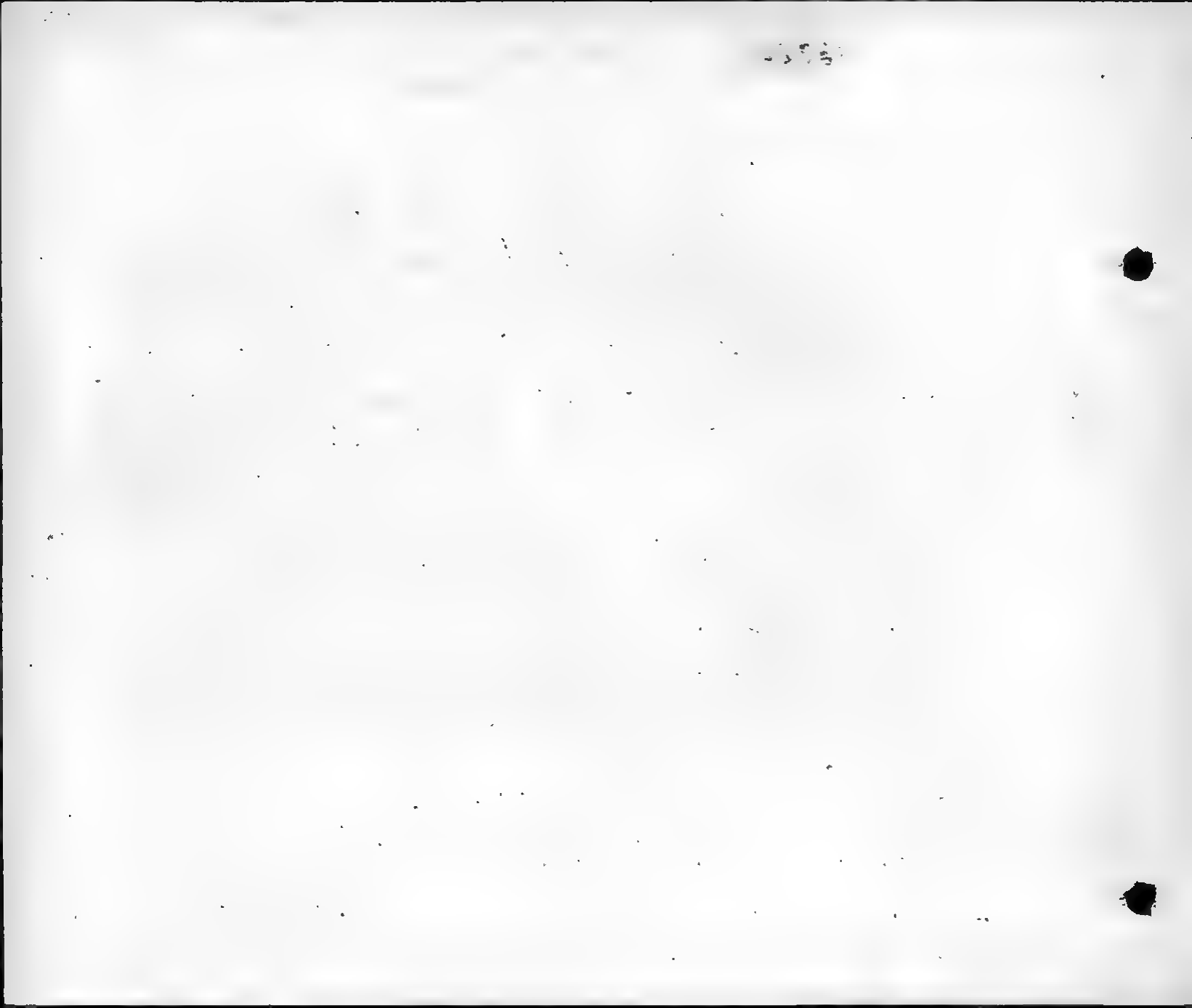
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN Tb <u>2 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hayward</u> Middle <u>Roy</u> Last <u>Henderson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 - 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HEAVY EQUIPMENT SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>London County VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Henry Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Martha Ellen Franks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>578-01-4557</u>	
17. INFORMANT <u>Rosealia Shinghuff</u> Address <u>6004 MILO DRIVE WOODACRE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Cerebrovascular accident - ?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> 6 years (c) <u>Cerebral vascular insufficiency</u> 1 1/2 years INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LACERATION OF CHIN IN FALL</u> 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>neither</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell forward in living room, striking chin on furniture.</u>			
20c. TIME OF INJURY Month <u>3</u> Day <u>5</u> Year <u>1960</u> Hour <u>2 p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>HOME ADDRESS</u>	
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>60</u> , to <u>3-6</u> , 19 <u>60</u> that I last saw the deceased alive on <u>3-6</u> , 19 <u>60</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above <u>Patient under care of Dr. William Howell and Arthur Husted.</u>			
ACTUAL SIGNATURE <u>Edward W. Youngblood, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Clinic</u> DATE SIGNED <u>3-6-60</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD, MD</u>		<u>Washington 15, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>3-8-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WARRENTON, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawlis sons</u> ADDRESS <u>1756 Pa. Ave. NW, Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Husted</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3571

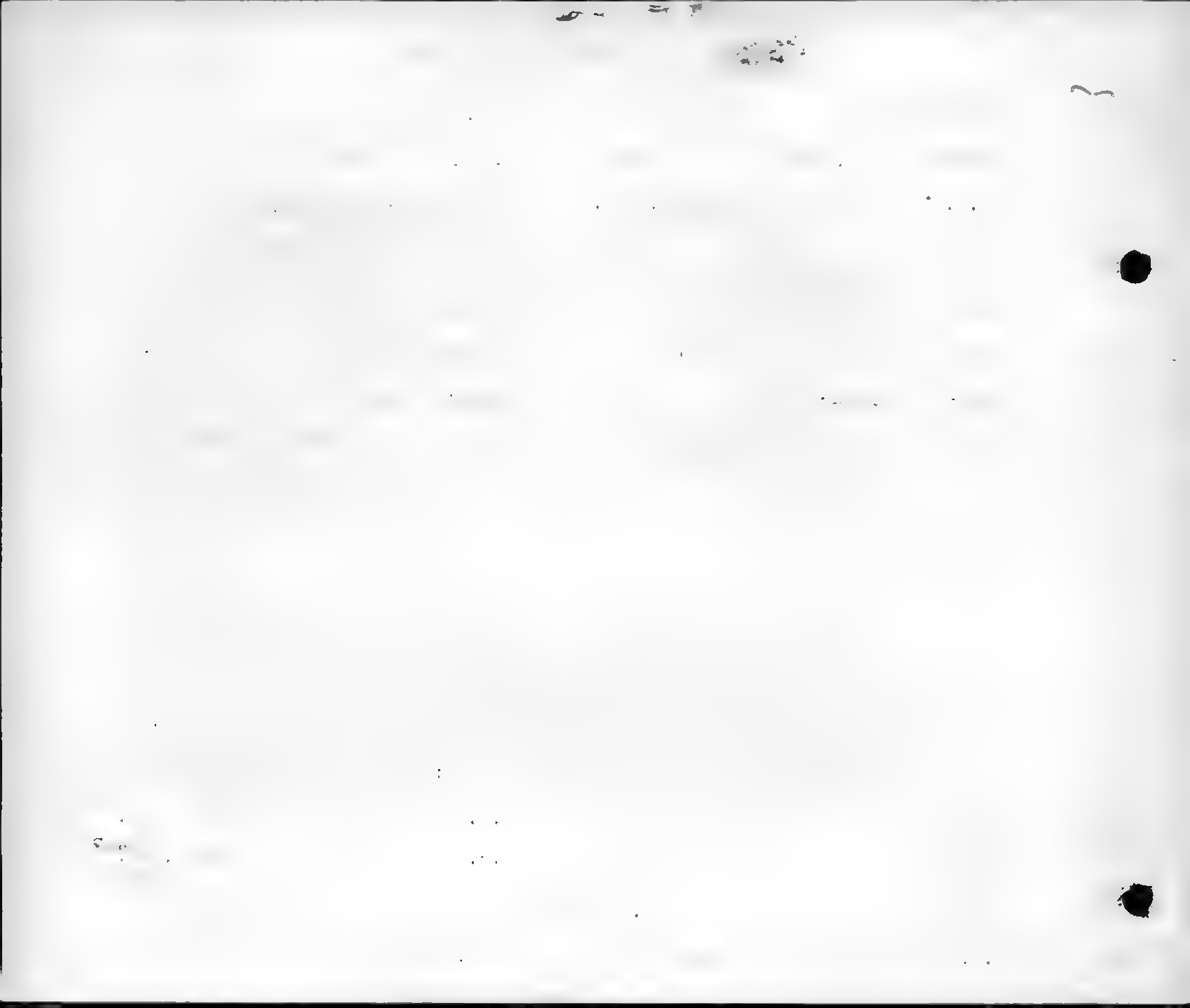
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> c. LENGTH OF STAY IN 1b <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Bermuda</b> b. COUNTY <b>U.S. Naval Station</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>U.S. Naval Station</b> d. STREET ADDRESS <b>Navy #138 c/o FPO NY, NY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>John</b> Last <b>HENDERSON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-9-57</b>	
9. AGE (In years last birthday) <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b>		11. IF UNDER 24 HRS Days <b>2</b>		12. IF UNDER 24 HRS Hours <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>James (n) Henderson</b>				14. MOTHER'S MAIDEN NAME <b>Deloris FERRI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>(Father) James Henderson</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Longental Heart disease (atrio-ventricular canal, complete)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> (c) <b>2 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>154.5</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3 February</b> , 19 <b>60</b> , to <b>16 March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>16 March</b> , 19 <b>60</b> , and that death occurred at <b>9:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>James E. Mc Clenathan</b> ACTUAL SIGNATURE <b>J.E. MC CLENATHAN CDR MC USN</b> PHYSICIAN'S NAME (Type) <b>U.S. Naval Hospital, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-18-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>New London, Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b>				ADDRESS <b>557 Wisconsin Ave. Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 21 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3572

CERTIFICATE OF DEATH

Reg. Dist. No. 215

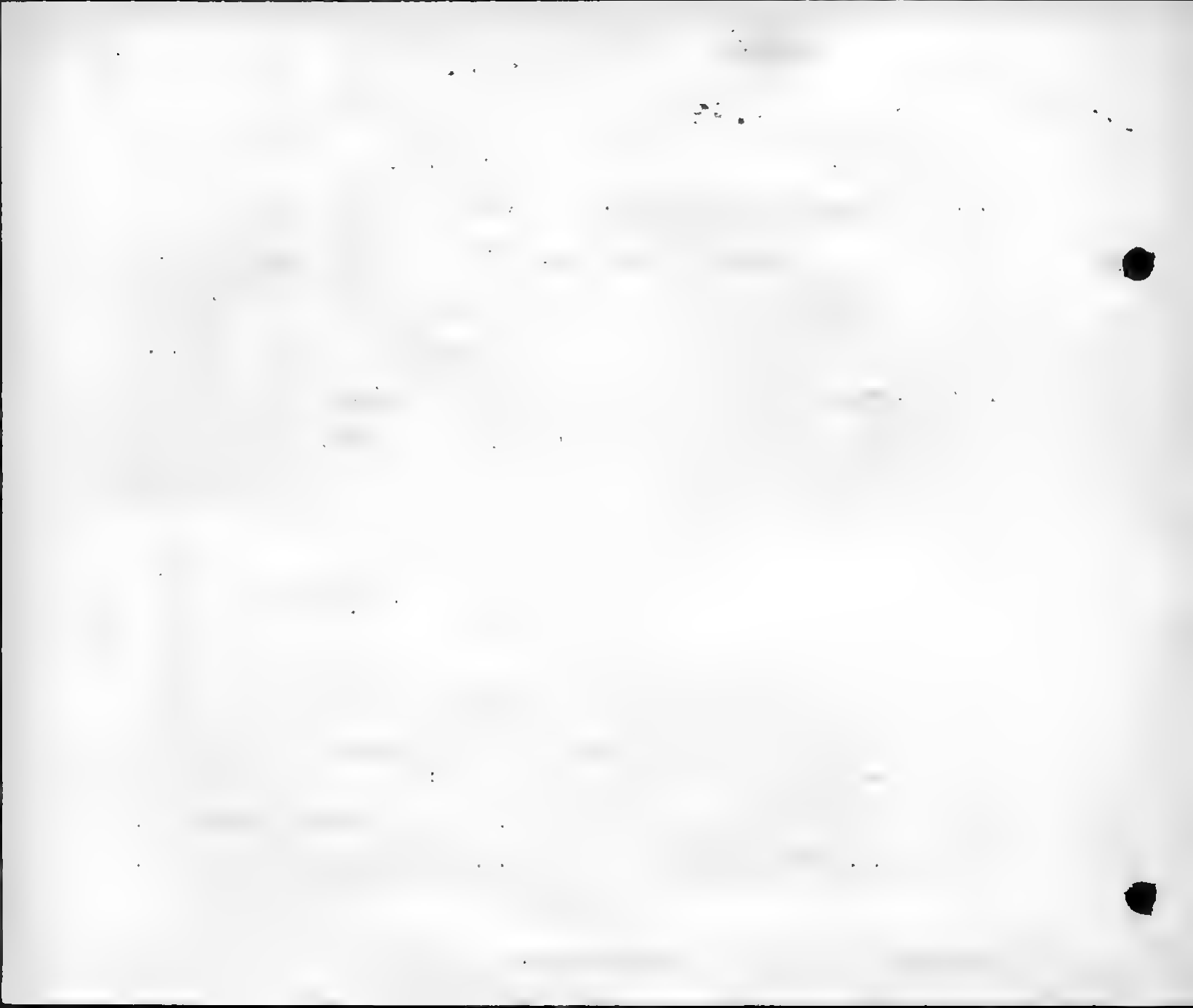
Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gordonsville</b> c. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Andrew Dean HENNESSEE</b>				4. DATE OF DEATH Month Day Year <b>March 9 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-60</b>	
9. AGE (In years lost birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 2</b>		IF UNDER 24 HRS Hours Min. <b>2 2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George H. Hennessee</b>				14. MOTHER'S MAIDEN NAME <b>Louis ACKERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(Father) George H. Hennessee</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>sudden cardiovascular collapse</b> 7-6-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>chronic starvation and depletion</b> DUE TO (c) <b>congenital stenosis, jejunum with " "</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>recurrent intestinal obstruction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>8 wks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 March</b> 19 <b>60</b> to <b>9 March</b> 19 <b>60</b> , that I last saw the deceased alive on <b>9 March</b> 19 <b>60</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 3-9-60</b>							
ACTUAL SIGNATURE <b>G.B. Avery</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>G.B. AVERY LT MC USN</b>		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Orange Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Orange Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Tyson Wheeler Funeral Home Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

Now 4/1/60

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<b>PLACE OF DEATH</b> a. COUNTY <u>Maryland</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>		d. STREET ADDRESS <u>1120 L St. N.E.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GENEVIEVE</u> Middle <u>M.</u> Last <u>HENNESSEY</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1917</u>
9. AGE (In years last birthday) <u>42</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hennessey</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hennessey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-11-111111</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>443X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Nov</u> Day <u>19</u> Year <u>1959</u> a. Hour <u>11:30</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5206 Norway Dr.</u>	20f. (City or town) (County) (State) <u>Prince Georges Maryland</u>
21. I certify that I attended the deceased from <u>Nov. 19, 1959</u> to <u>March 8, 1960</u> that I last saw the deceased alive on <u>March 8, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry Rosen</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u>	
PHYSICIAN'S NAME (Type) <u>Henry Rosen</u>		DATE SIGNED <u>3/8/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>	22d. LOCATION (City town or county) (State) <u>Hyattsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		ADDRESS <u>5163 Wisconsin</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>
24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



3573

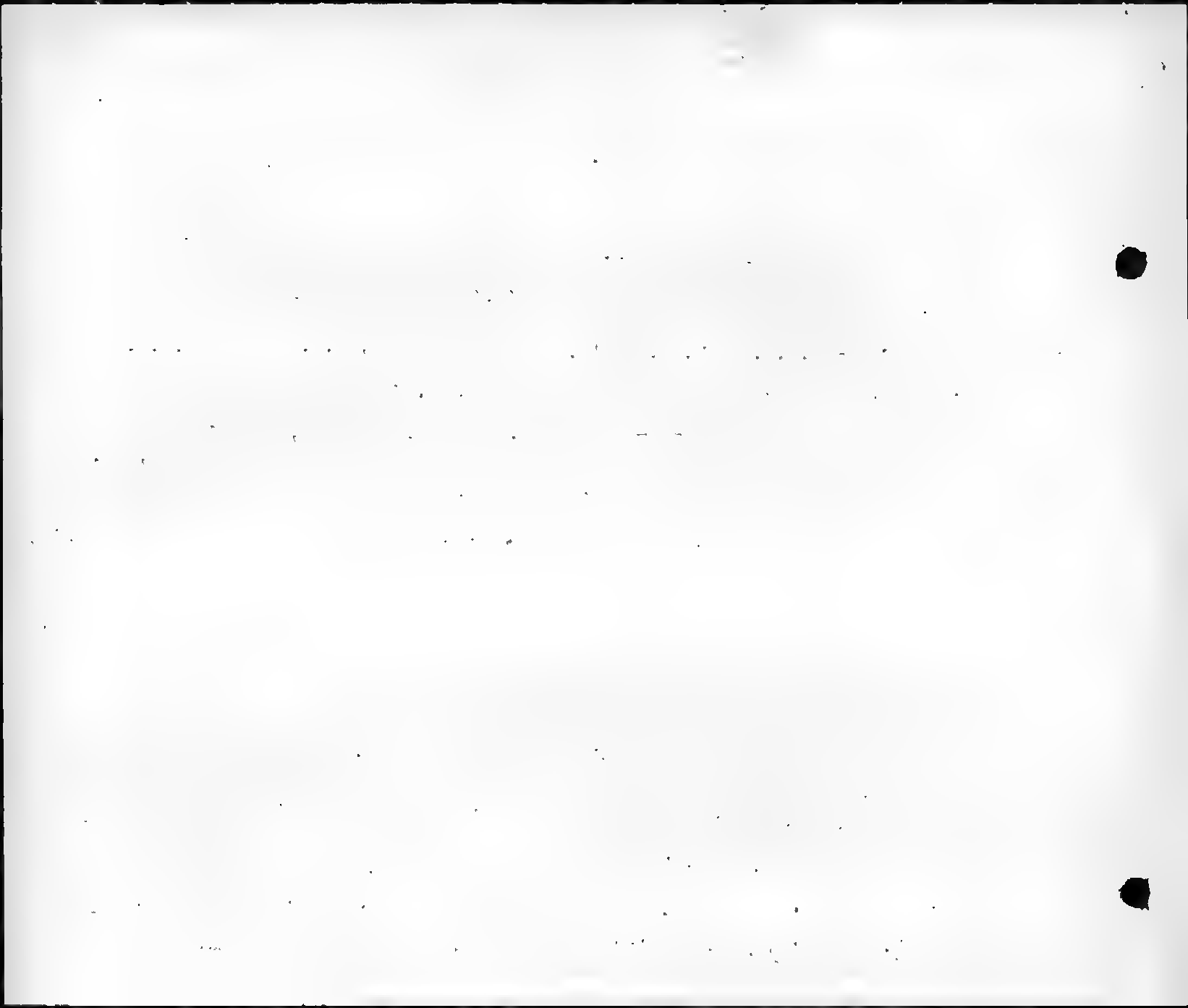
CERTIFICATE OF DEATH

03481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtensville</b> c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2801 Duvall Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtensville</b> d. STREET ADDRESS <b>2801 Duvall Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>H.</b> Last <b>Herriman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/06</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance - N.O.L.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BERTRAM A. HERRIMAN</b>		14. MOTHER'S MAIDEN NAME <b>LYDIA E. HOWES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-05-4885</b>	
17. INFORMANT <b>Mrs. Annie M. Herriman, 2801 Duvall Road Burtensville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Coronary thrombosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>3 months</b>		19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12, 1959</b> , to <b>March 30, 1960</b> , that I last saw the deceased alive on <b>March 24, 1960</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>345 University Blvd, West Silver Spring, Md.</b> DATE SIGNED <b>3/30/60</b>			
ACTUAL SIGNATURE <b>Raymond Bradshaw</b> M.D.		DATE SIGNED <b>3/30/60</b>	
PHYSICIAN'S NAME (Type) <b>Raymond Bradshaw</b>		ADDRESS <b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/2/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PIMPHREY, INC.</b> <b>Raymond A. Zicka</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3473

## CERTIFICATE OF DEATH

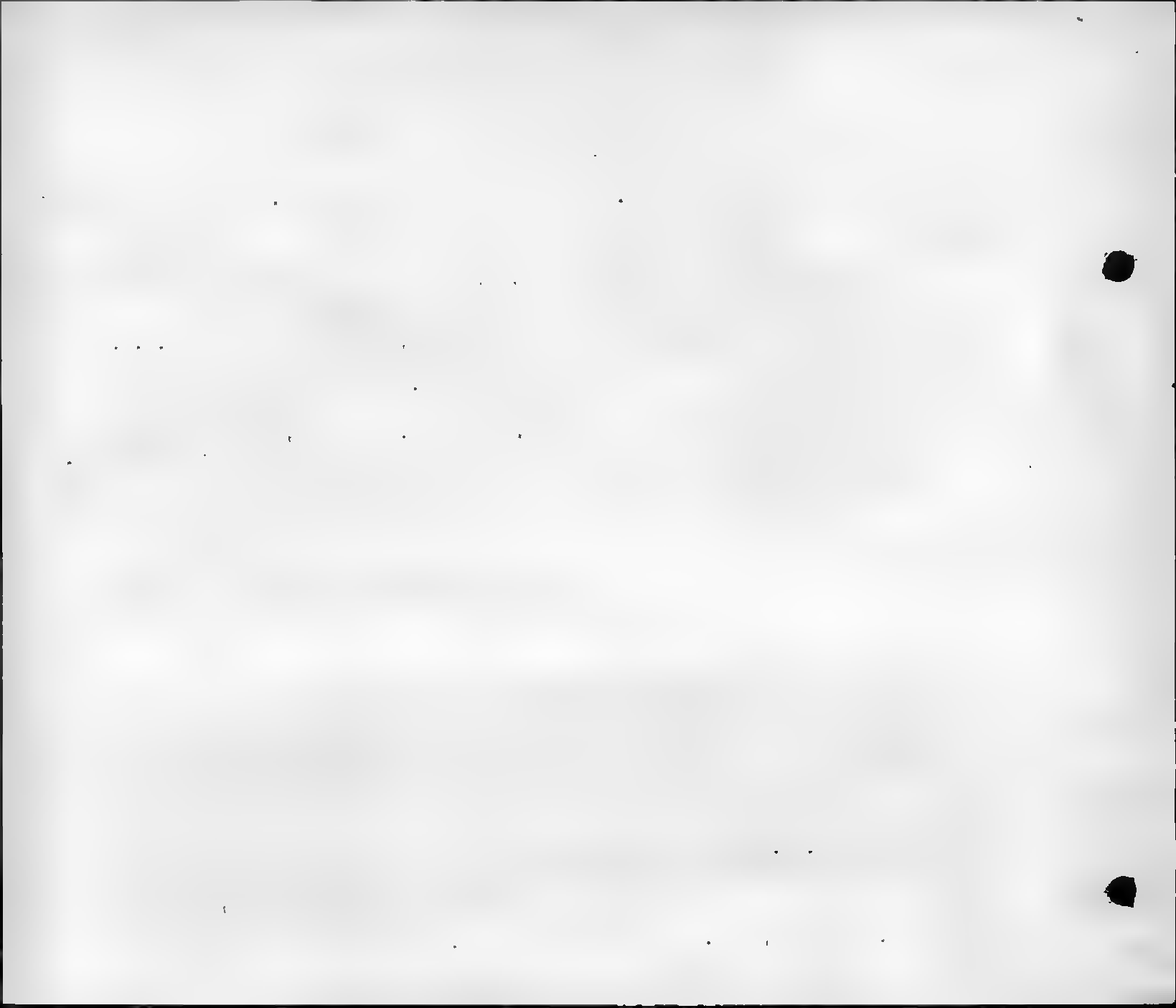
03482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>17</b> <b>12 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Philadelphia Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>	
f. STREET ADDRESS <b>304 Philadelphia Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SOPHIA</b> Middle <b>ELEANOR</b> Last <b>HOBBS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/86</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>19</b> Min <b>60</b>	11. IF UNDER 24 HRS Months <b>1</b> Days <b>4</b> Hours <b>19</b> Min <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Highland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILBUR FISKE CISSEL</b>		14. MOTHER'S MAIDEN NAME <b>CLARA E. BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Mrs. Robert A. Phillips, 825 Violet Place</b>	
17. INFORMANT <b>Mrs. Robert A. Phillips, 825 Violet Place</b>		Address <b>Silver Spring, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE UTERUS</b> DUE TO <b>174 X</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Silver Spring, MD</b> ONSET AND DEATH <b>1 YEAR</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AURICULAR FIBRILLATION</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAR. 1959</b> , to <b>MAR. 4, 1960</b> , that I last saw the deceased alive on <b>3 MAR. 1960</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L.B. Snow</b>		DATE SIGNED <b>7950 N.H. AVE. LANGLEY PARK MD 3/4/60</b>	
PHYSICIAN'S NAME (Type) <b>L. B. SNOW</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MOUNT VIEW CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HOWARD COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GARNER E. BUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>MAR 7 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3574

## CERTIFICATE OF DEATH

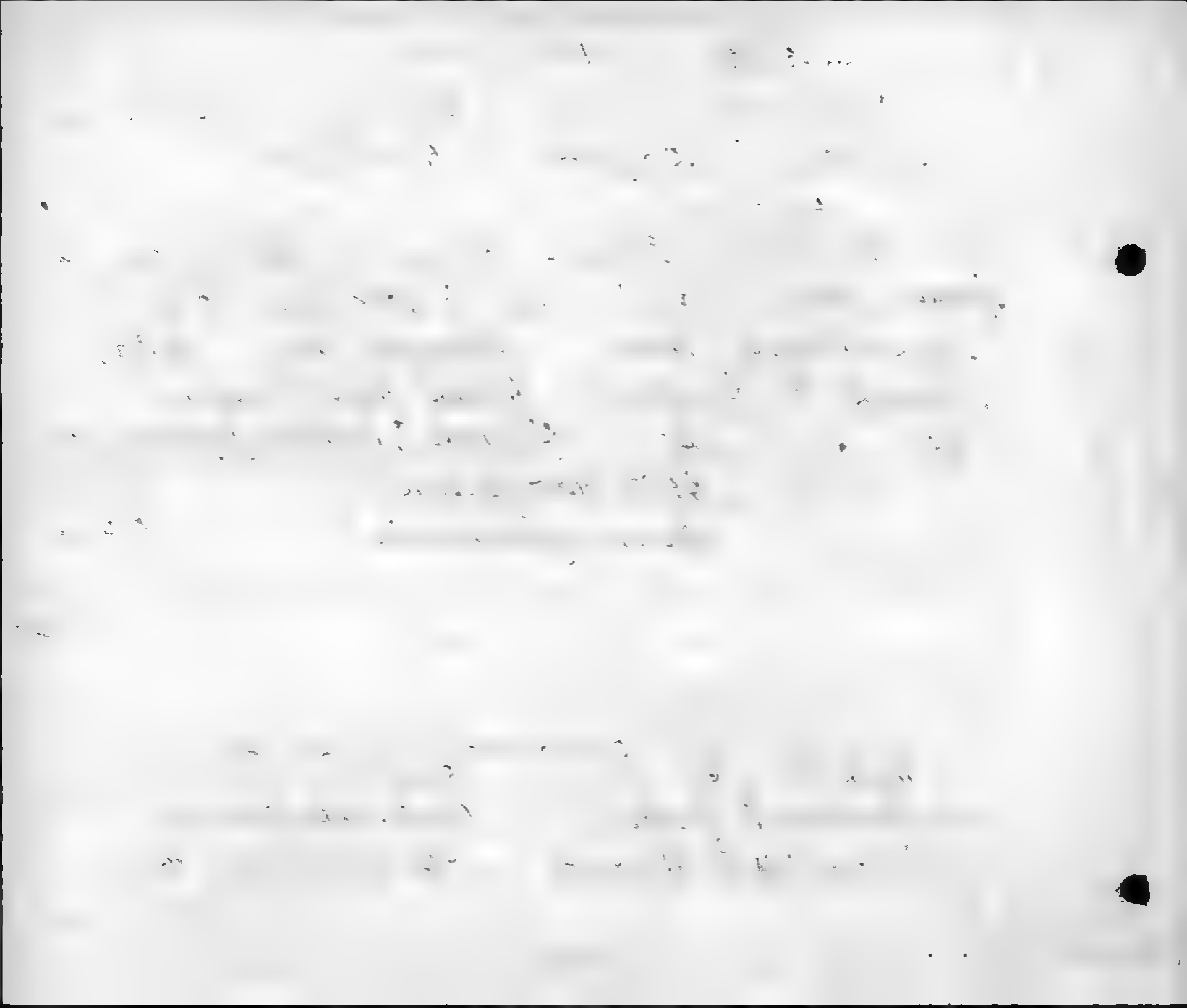
Reg. Dist. No.

03483

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattstown</i>	c. LENGTH OF STAY IN 1b <i>28 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattstown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Minerva</i> First <i>Cragin</i> Middle <i>Horne</i> Last		4. DATE OF DEATH <i>March</i> Month <i>22</i> Day <i>1960</i> Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-6-1866</i>
9. AGE (In years last birthday) <i>93</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>3</i> Days <i>16</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Philip C. Quadow</i>		14. MOTHER'S MAIDEN NAME <i>Achsa Ann Quadow</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>Edmond E. Washburn, Hyattstown, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure</i> <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumo-pneumonia</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i> <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <i>3-18-1960</i> to <i>3-22-1960</i> , that I last saw the deceased alive on <i>March-22-1960</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7-Brooks Avenue Gaithersburg, Md</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-25-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Christian Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattstown, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Burdette, Hyattstown, Maryland</i>		24a. REC'D BY REGISTRAR <i>MAR 24 '60</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3440

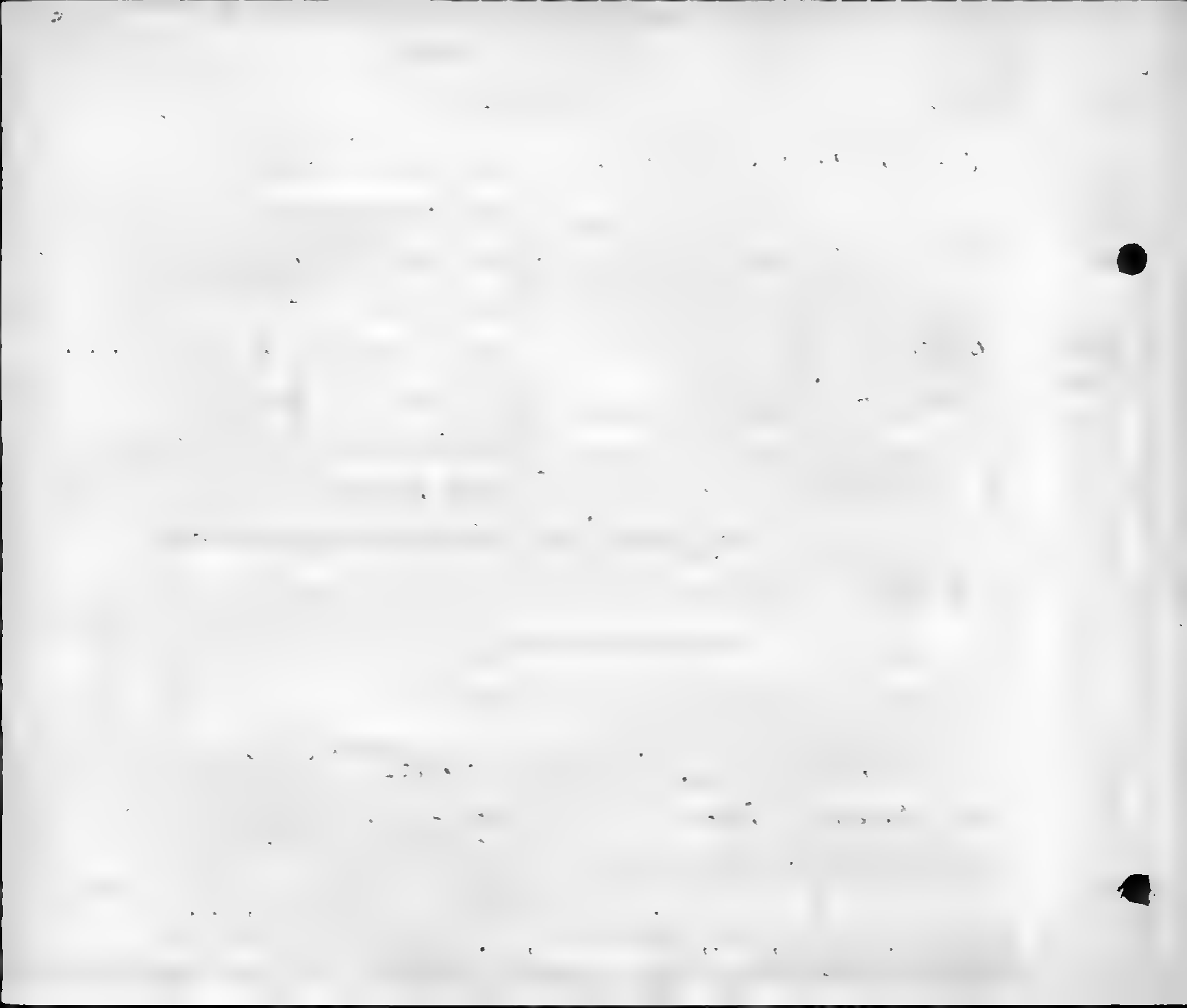
## CERTIFICATE OF DEATH

Reg. Dist. No.

03484

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVERSPRING</u>				c. LENGTH OF STAY IN 1b <u>29 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1910 Luzerne Avenue</u>				1 d. STREET ADDRESS <u>1910 LUZERNE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>HUNTER</u> Last <u>HUNTER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 9 1878</u>		9. AGE (In years, last birthday) <u>87 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL MULLOY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>REGINA HUNTER 1910 LUZERNE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>WASHINGTON, D.C.</u>		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>DEC 1955</u> to <u>MARCH 3, 1966</u> , that I last saw the deceased alive on <u>MARCH 1, 1966</u> , and that death occurred at <u>11:53 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>SARAH E. GLOVER</u>				M.D. <u>10126 CEDAR LANE</u>		DATE SIGNED <u>3-3-60</u>	
PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>				ADDRESS (Street, city or town, state) <u>KENSINGTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3476

## CERTIFICATE OF DEATH

Reg. Dist. No.

03485

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If instit. on, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Iora</u> Middle <u>Adell</u> Last <u>Hurd</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-77</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Winifield S. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>W.S.H. Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremic State - Ch. Nephritis.</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>  </u> 19 <u>54</u> to <u>March 24</u> 19 <u>60</u> that I last saw the deceased alive on <u>March 24</u> 19 <u>60</u> and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		DATE SIGNED <u>3/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Springfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>East Springfield, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	
DATE <u>MAR 28 '60</u>		DATE <u>  </u>	



3575

## CERTIFICATE OF DEATH

Reg. Dist. No.

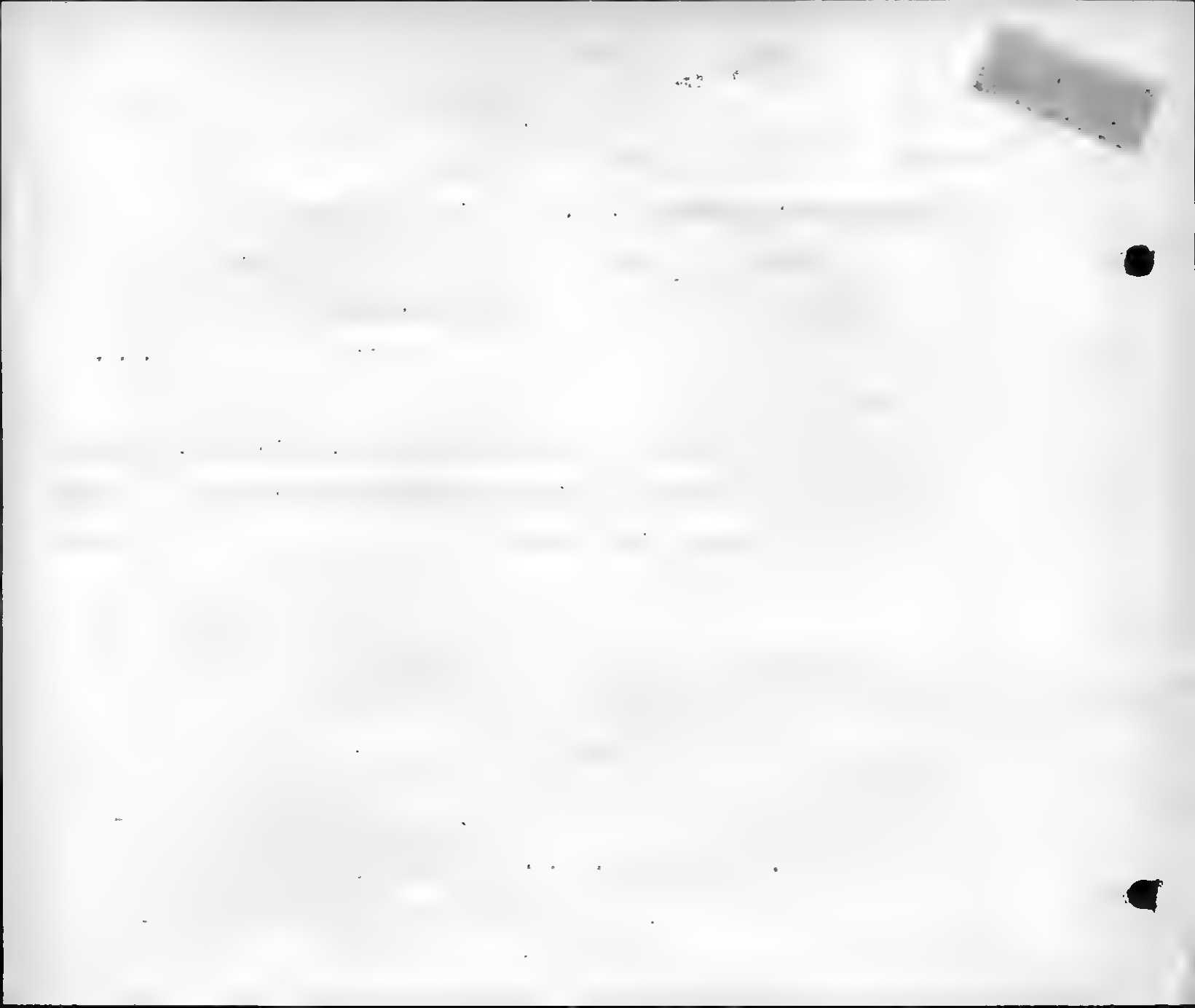
03486

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If instit on Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>Fairfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>26 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bridgeport</b>	
		f. STREET ADDRESS <b>152 Mill Hill Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Ann</b> Last <b>Ivan</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 24, 1892</b>
9. AGE (In years lost birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Kurovics</b>		14. MOTHER'S MAIDEN NAME <b>Rosalie Vereb</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Disease with Uremia and Acidosis</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoid</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 21 1960</b> to <b>March 18 1960</b> , that I last saw the deceased alive on <b>March 18 1960</b> , and that death occurred at <b>12:10pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center Bethesda 14, Maryland</b> DATE SIGNED <b>3-18-60</b>			
ACTUAL SIGNATURE <b>Joseph C. Greenfield Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOSEPH C. GREENFIELD, JR., M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Transit 3-19-60</b>		<b>St. Michaels Cemetery Stratford, Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 22 '60</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





3576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>32 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>917 East E Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Edward</b> Last <b>Jacobs</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1957</b>	9. AGE (In years last birthday) <b>3</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			
13. FATHER'S NAME <b>Charles E. Jacobs</b>			14. MOTHER'S MAIDEN NAME <b>Clara Orndorff</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-Intestinal Hemorrhage</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>1 year</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February 22, 1960</b> to <b>March 25, 1960</b> , that I last saw the deceased alive on <b>March 25, 1960</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-24-60</b>							
ACTUAL SIGNATURE <b>L. A. Gaydos</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-26-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers &amp; Co. Inc.</b>		ADDRESS <b>1400 Chapin St. N.W.</b>		24a. REC'D BY REGISTRAR <b>MAR 29 1960</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**LOCAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within \_\_\_\_\_ hours after death Page 4

obtained by the hospital or attending physician.

**LOCAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it must be signed in by the funeral director, \_\_\_\_\_ and \_\_\_\_\_

3577

## CERTIFICATE OF DEATH

Reg. Dist. No.

03488

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>100 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>(None)</b> Last <b>Jacobstein</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1925</b>
9. AGE (In years last birthday) <b>34 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin A. Jacobstein</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Weitzman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO <b>207-12-1933</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Metastatic Synovioma, Lungs</b> DUE TO <b>Synovioma, Left Knee</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Synovioma, Left Knee</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 14, 1959</b> to <b>March 23, 1960</b> , that I last saw the deceased alive on <b>March 23, 1960</b> , and that death occurred at <b>3:10p M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-23-60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D.			
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Springton Md. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amos H. Hanlon</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 29 '60</b>	
ADDRESS <b>3831-GA Ave NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death

3 and 4 to be enclosed for use as the Burial Certificate. The registrars must be present at the time of the burial, cremation, or removal, and in any event within 72 hours of death

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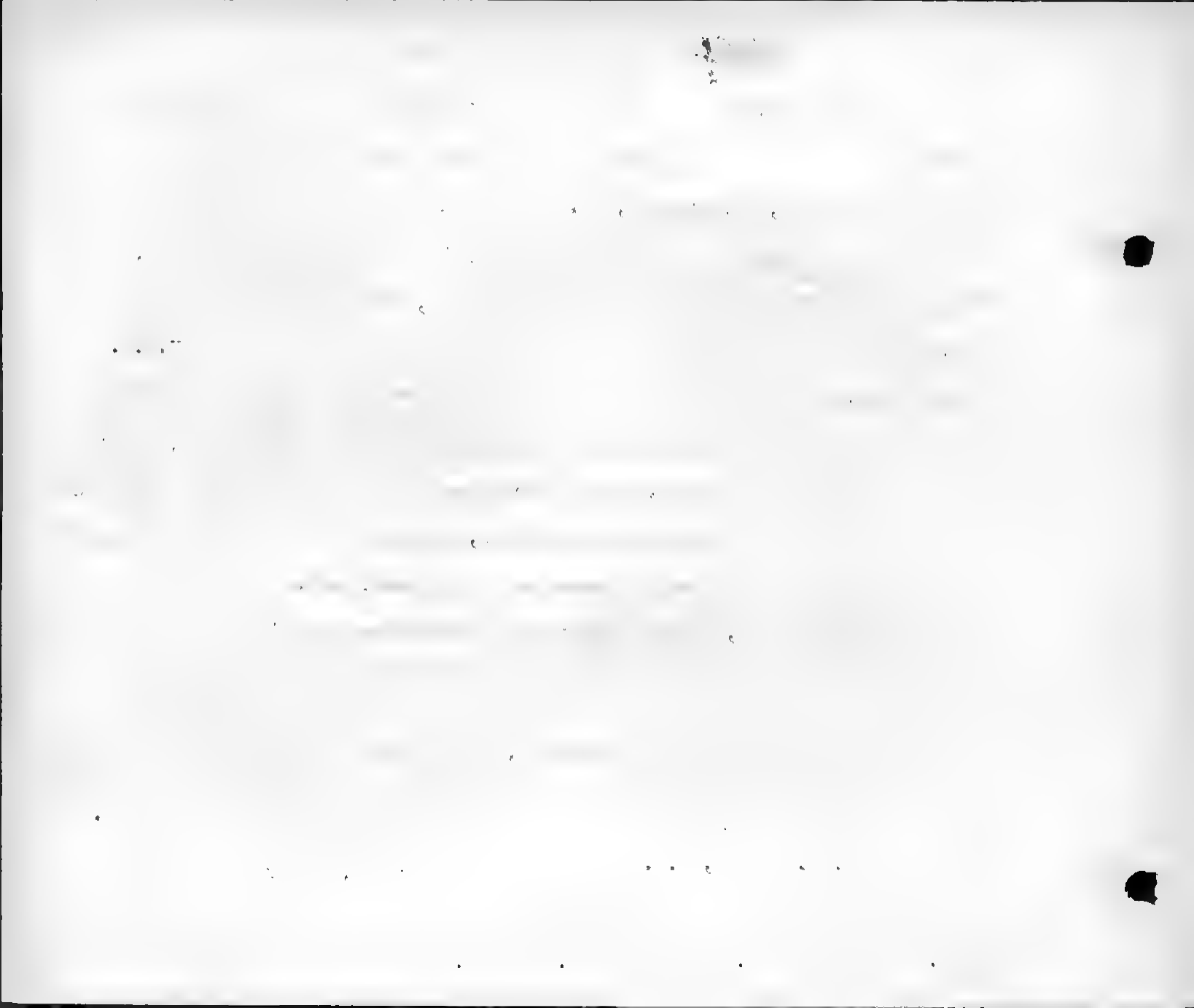
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3578

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Henrico</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>90 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS <b>1126 South Bonsal Street</b>			
3 NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>Anna</b> Last <b>Janiski</b>		4 DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>October 9, 1908</b>
9 AGE (In years last birthday) <b>51</b>		10 IF UNDER 1 YEAR Months <b>51</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11 IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stanley Staszak</b>		14. MOTHER'S MAIDEN NAME <b>Anna Romanik</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unascertainable</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular hemorrhage</b> DUE TO Chronic pyelonephritis, uremia DUE TO Collagen disease with cryoglobulinemia		INTERVAL BETWEEN ONSET AND DEATH <b>56 hours</b> <b>7 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary infarctions, splenic infarction, hemorrhage cystitis</b>		19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 3, 1959</b> to <b>March 2, 1960</b> , that I lost saw the deceased alive on <b>March 2, 1960</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul J. Schwab</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Paul J. Schwab, M.D.</b>		DATE SIGNED <b>2 Mar. 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 5, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary Cem. Baltimore, Maryland</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>		24b. REC'D BY REGISTRAR <b>Mar 4 '60</b>	
ADDRESS <b>3000 E. Baltimore St., Balto.</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



# 1 8 166 1 2 VS. A15ME(S) 5M 9/55 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain to the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal. 1 8 166 1 2 VS. A15ME(S) 5M 9/55 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain to the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## 3455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK 12, MARYLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>				d. STREET ADDRESS <u>712 GILBERT ST. Apt 1</u>			
3. NAME OF DECEASED (Type or print) (MRS.) <u>ANN</u> First <u>ELIZABETH</u> Middle <u>JATMAN</u> Last				4. DATE OF DEATH Month <u>MAR</u> Day <u>3rd</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-16</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HANALEI, HAWAII</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Wong Chai</u>				14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE CHANG SEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>TAKOMAPARK. MR. ARNOLD JATMAN - 712 Gilbert St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Acute Congestive heart failure</u> DUE TO (b) <u>Congenital heart disease</u> DUE TO (c) <u>life</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St NW 296</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3579

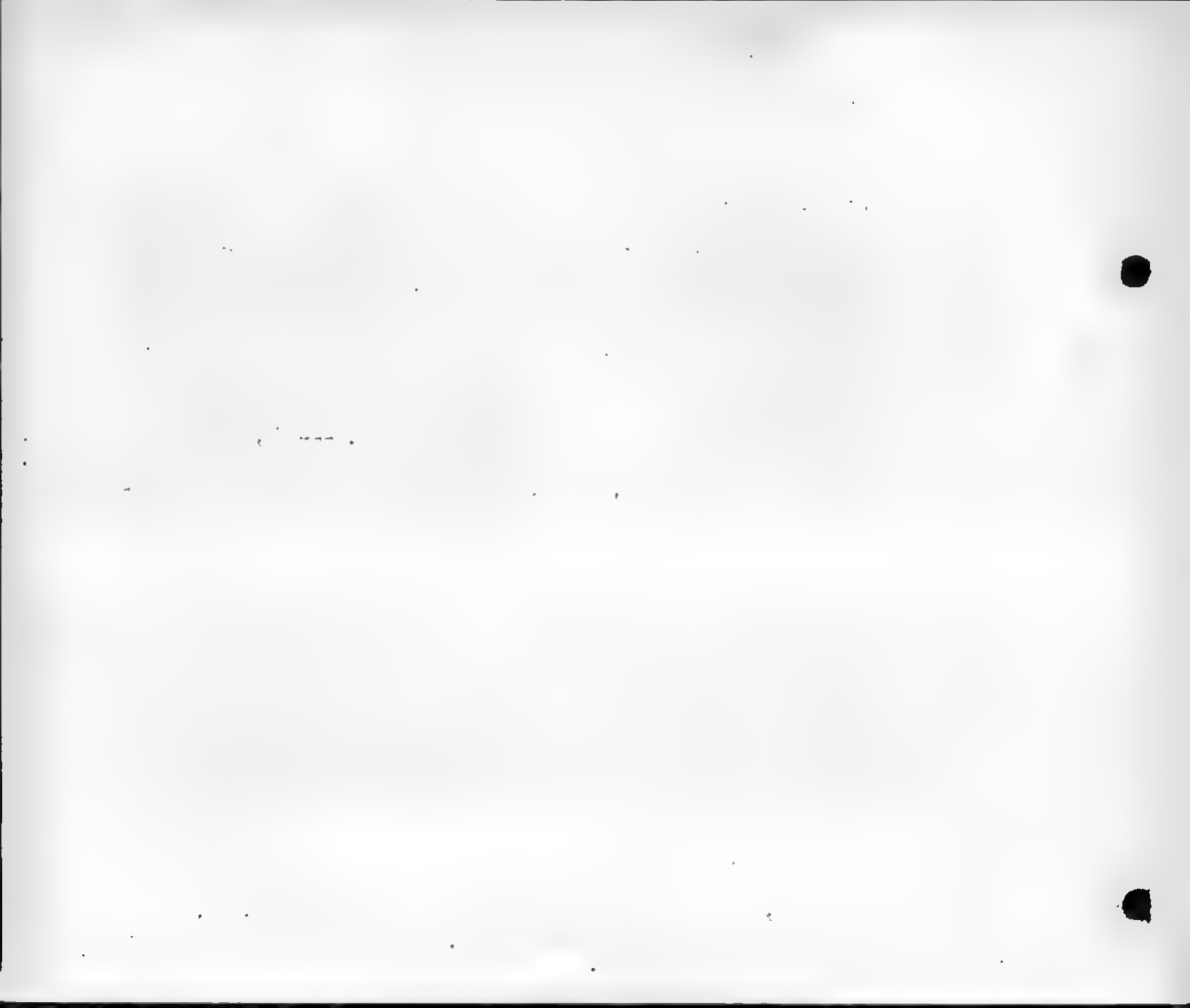
## CERTIFICATE OF DEATH

03491

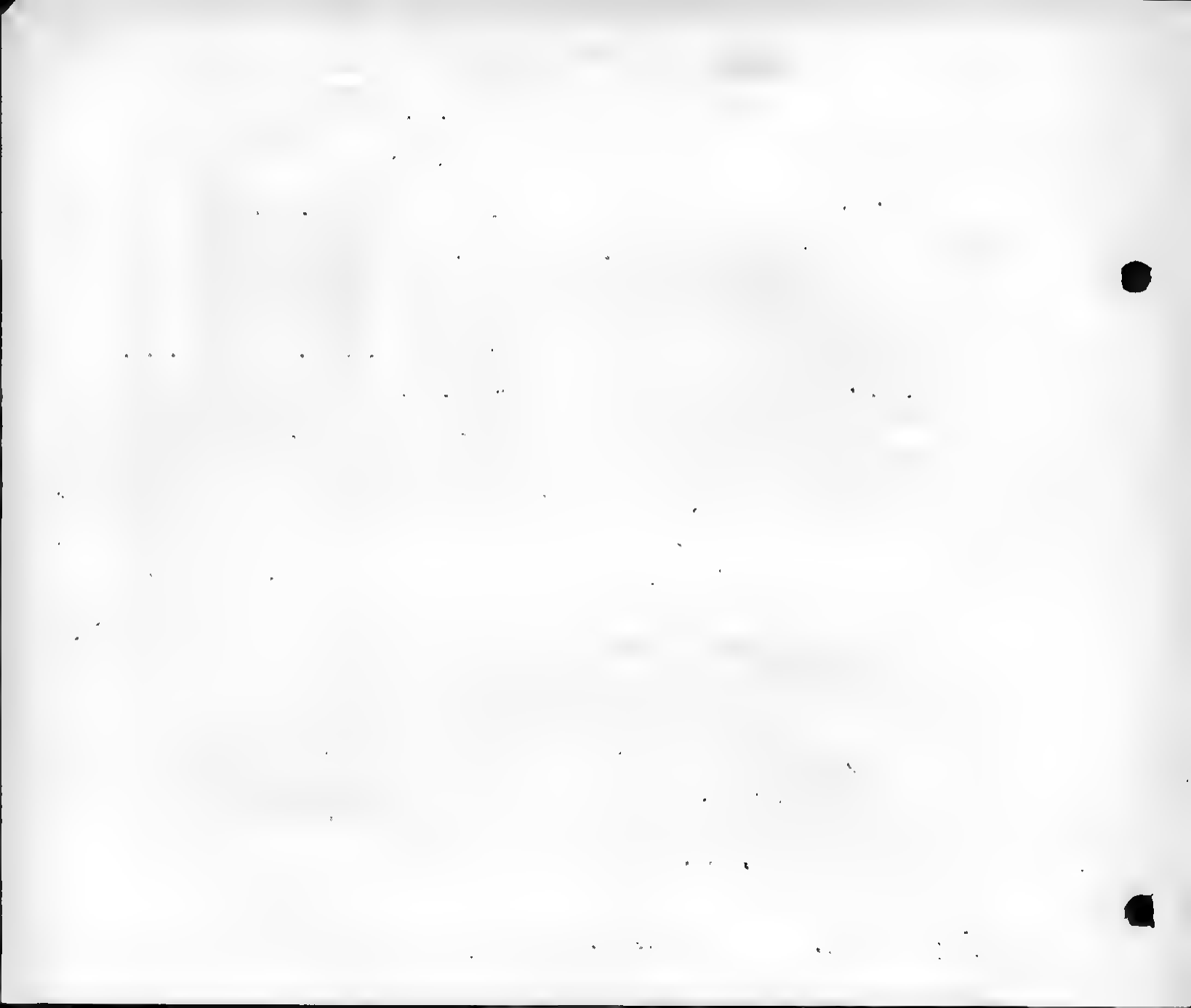
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>17.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda</b>		d. STREET ADDRESS <b>Rt 2 Box 137</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Andrew Herbert Johnson</b>		4. DATE OF DEATH Month Day Year <b>March 20 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-1879</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Christine Linguist</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Hazel SCHIEKE, Rt. Box #2, Box 137, Edgewater, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Lobar, Right</b> <b>141.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Cell, Carcinoma of Tongue</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4-5 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>18 February, 19 60</b> , to <b>20 March, 19 60</b> , that I last saw the deceased alive on <b>20 March, 19 60</b> , and that death occurred at <b>225 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town state) DATE SIGNED			
ACTUAL SIGNATURE <b>Vernon N. Houk</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Vernon N. HOUK, LT MC USN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>Mar 23, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetary</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John TAYLOR &amp; Sons,</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 24 '60</b>	
ADDRESS <b>147 Duke of Gloucester St. Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 of the retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>3244 Chestnut St., N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle <b>B.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/21</b>
9. AGE (In years last birthday) <b>38</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Fall River, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter F. Brow</b>		14. MOTHER'S MAIDEN NAME <b>Ann O'Donnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Husband</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>190.9</b> DUE TO <b>Encephalomalacia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic melanoma of the skin</b> DUE TO <b>Primary melanoma of the skin</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 Days</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 14</b> , 19 <b>59</b> , to <b>March 2</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 2</b> , 19 <b>60</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Suburban Hospital</b> DATE SIGNED ACTUAL SIGNATURE <b>Robert Brewer</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert Brewer, M.D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF	
<b>Removal</b>		<b>3/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Conestoga Mem. Pk.</b>		<b>Lancaster, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b> ADDRESS <b>3004 5th St. N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Jones</b>	



# FOR STATE HEALTH DEPT.

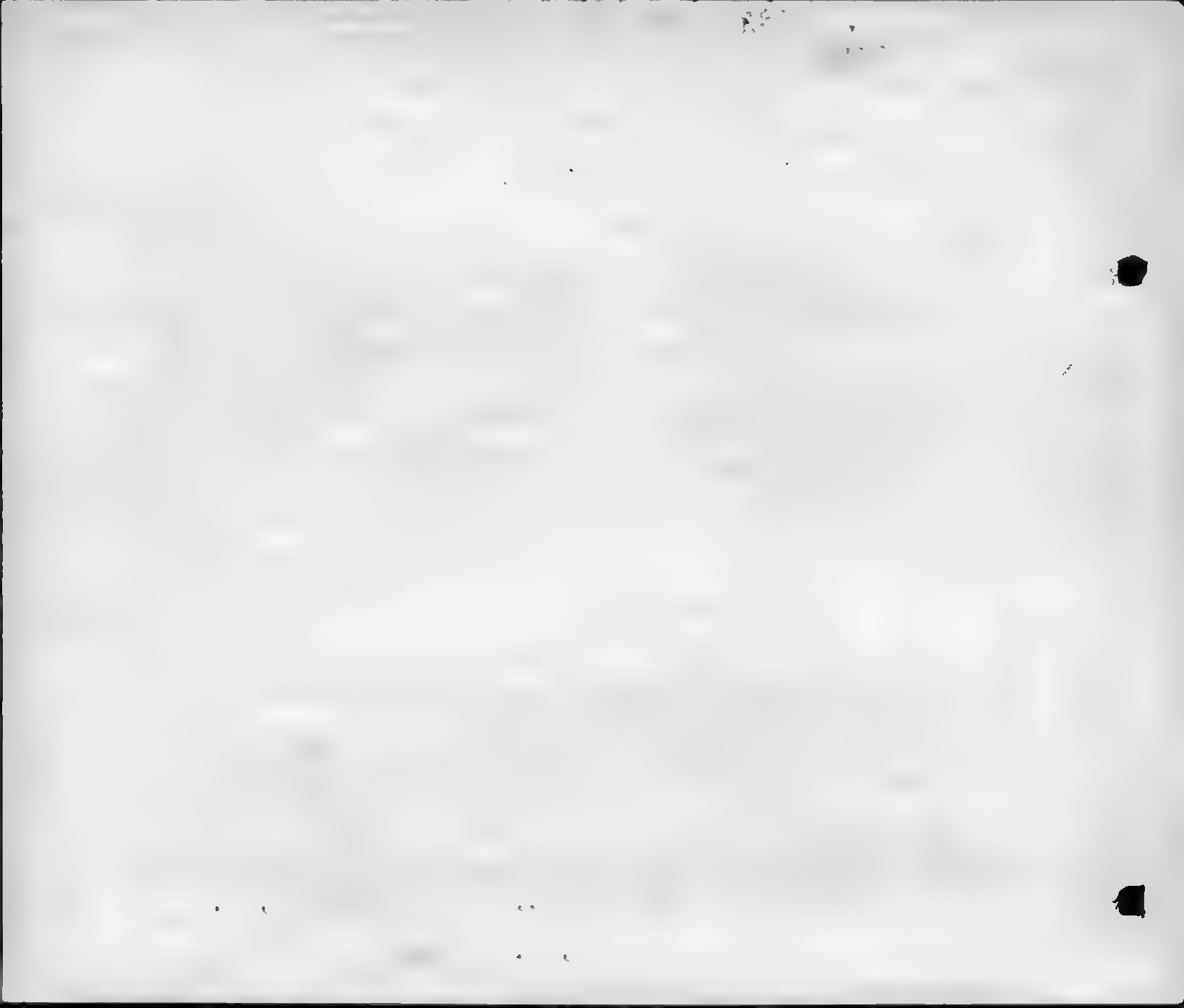
**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03493

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address) <u>Montgomery Co. Gen. Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <b>B-2</b> d. STREET ADDRESS <u>Stewart Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <u>Anthony Tyrone Jones</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>Mar 27 1960</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>12-22-59</u>		9. AGE (In years last birthday) <u>3</u> <u>5</u> <u>7</u> yrs. Months Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>md Montg. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>md Montg. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>md Montg. Co.</u>		13. FATHER'S NAME <u>Walter Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Fraunce Poge</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Walter Jones</u>		16. SOCIAL SECURITY NO. <u>Fraunce Poge</u>			
17. INFORMANT <u>Fraunce Jones (mother)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Upper Respiratory Infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-27-60</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>			
22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>		23. FUNERAL DIRECTOR <u>Robert L. Suroch</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 4 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Anthony L. Haines</u>		74277 XV5					



3441

## CERTIFICATE OF DEATH

03494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>Appros. 6 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2905 SHERATON ST.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2905 SHERATON STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BETRUE</b> Middle <b>PRICE</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/85</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EPHRIAM PRICE</b>		14. MOTHER'S MAIDEN NAME <b>MARY RICHARDS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>Mr. H. Jones, 2905 Sheraton St., Wheaton Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>44' x</b> DUE TO <b>Uremia due to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Nephrosclerosis due to</b> DUE TO <b>10 year</b> (c) <b>Arterio sclerosis</b> <b>year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/10/58</b> to <b>3/8/60</b> , that I last saw the deceased alive on <b>5/18/60</b> , 19 <b>60</b> , and that death occurred at <b>5A</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md.</b> DATE SIGNED <b>3/8/60</b>			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 3/11/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL SHRINE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CENTERMORELAND, PENNSYLVANIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond E. Ziska</b>		24a. REC'D BY REGISTRAR <b>MAR 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



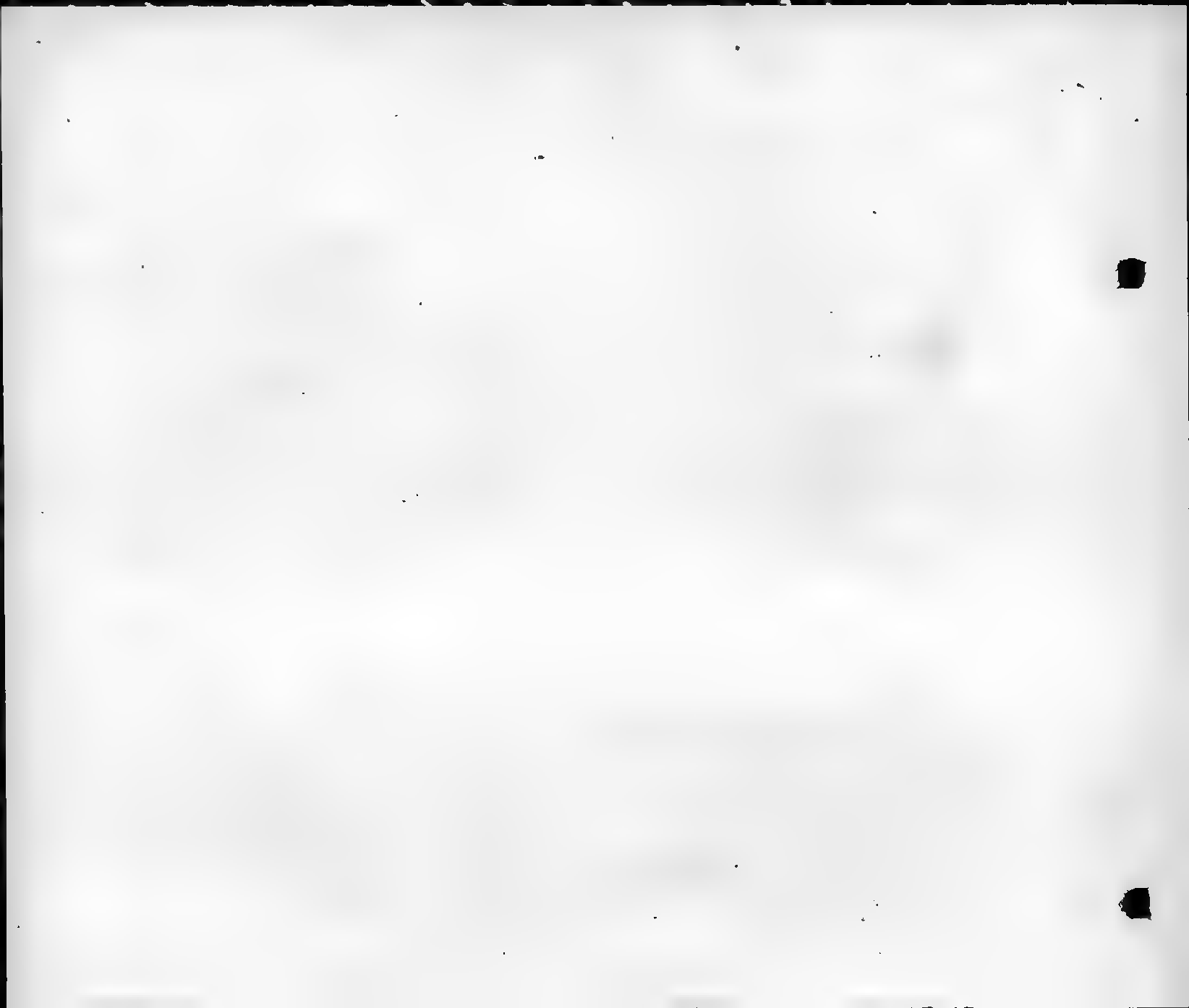


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3514 CERTIFICATE OF DEATH

03495

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>ROCKVILLE</u>				c. LENGTH OF STAY IN 1b <u>13 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5501 Golf Lane</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Rockville, Md</u>			
				d. STREET ADDRESS <u>5501 Golf Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Christopher</u> <u>Noland</u> <u>Jones</u>				4. DATE OF DEATH <u>March</u> <u>16</u> <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/1</u> <u>'59</u>	
				9. AGE (In years last birthday) <u>21</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<u>Maryland</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Stephen Noland Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ann Crowley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>—</u>			
17. INFORMANT <u>Mother.</u>				Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Overwhelming Virus Infection</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>15 March</u> <u>1960</u> , to <u>16 March</u> <u>1960</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>16 March</u> <u>1960</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Francis J. Troendle</u>				22b. DATE SIGNED <u>17 March 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>				22d. ADDRESS <u>809 VIERS MILL RD, ROCKVILLE Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>			
ADDRESS <u>Bethesda, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



03498

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)  
15M 9/55

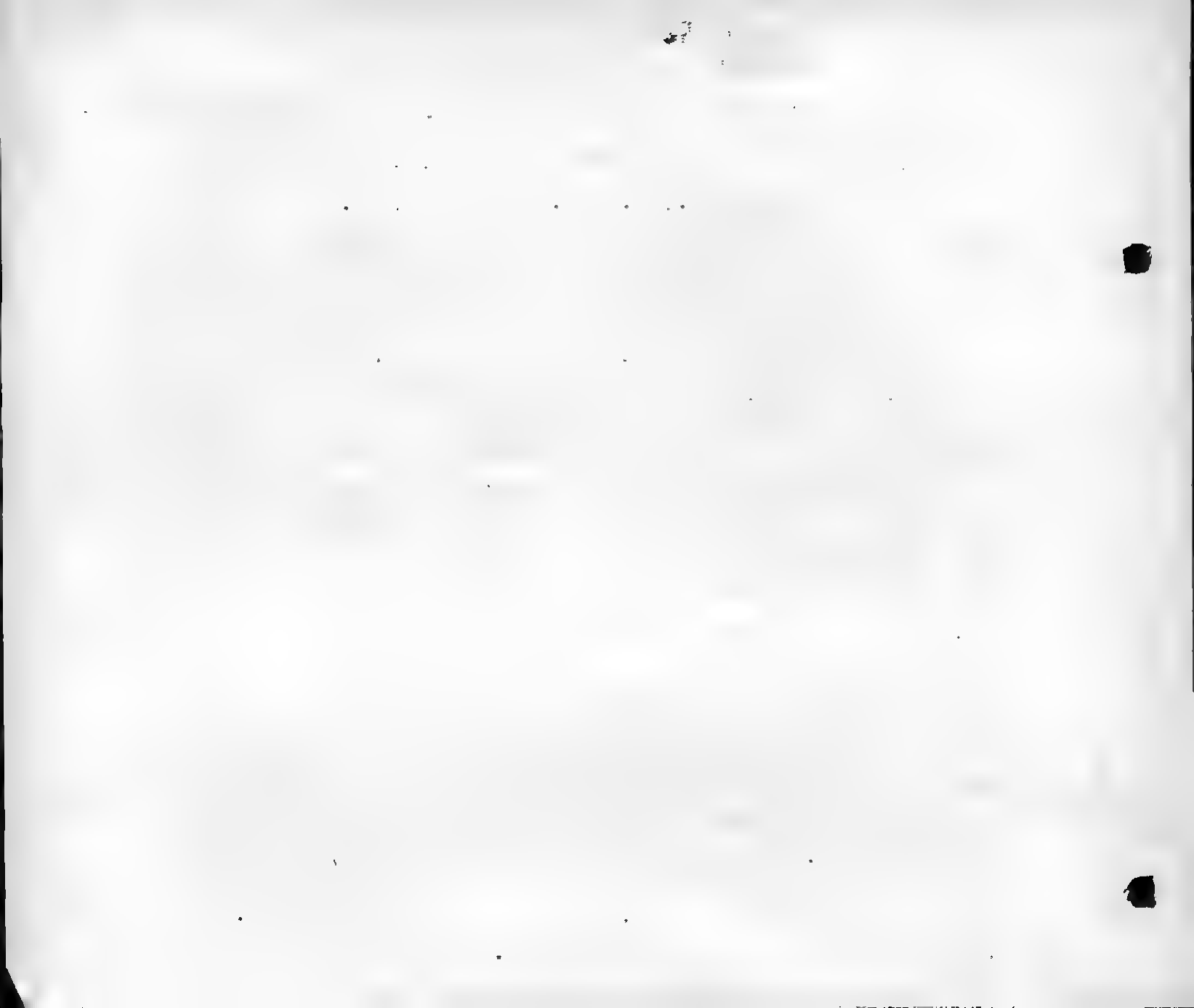
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same as 1A</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>12 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marguerite</u> Middle <u>F.</u> Last <u>Jordan</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4<sup>th</sup></u> Year <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1889</u>	
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>Indianapolis, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wright S. Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Sally Nueby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, at unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Helen Fisher</u>		Address <u>8617 Piney Branch Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>437.1 Acute Congestive Heart Failure</u> DUE TO (b) <u>Curricula fibrillation</u> DUE TO (c) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> <u>10+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deformity Ribs 18<sup>th</sup> chest &amp; back bone (congenital)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1948</u> to <u>March 4, 1960</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3900 Military rd N.W. D.C.</u> DATE SIGNED <u>3/4/60</u>			
ACTUAL SIGNATURE <u>Gilbert B. Rude</u> M.D.		PHYSICIAN'S NAME (Type) <u>Gilbert B Rude MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill C.</u>		22d. LOCATION (City, town, or county) (State) <u>Indianapolis Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Chalkers Co.</u>		ADDRESS <u>1400 E. 4th St. N.</u>	
24a. REC'D BY REGISTRAR <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Funder</u>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 3583  
 CERTIFICATE OF DEATH

03497

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>36 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. Gen. Hosp.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			
e. STREET ADDRESS <b>Rural Rt. 4</b>				f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Charles</b> Last <b>Kahler</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 60</b>			
5 SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/2/1898</b>	
9. AGE (In years lost birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Phillip Kahler</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dieker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-14-1632</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease with chronic heart failure</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>0</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Clarksville, Maryland</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 9, 1960</b> to <b>March 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1960</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above							
22a. SIGNATURE <b>Charles S. Whitaker</b>				22b. DATE SIGNED <b>March 10, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. S. Whitaker M.D.</b>				22d. ADDRESS <b>Clarksville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		23d. LOCATION (City, town, or county) (State) <b>Fulton, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. L. Evans</b>	



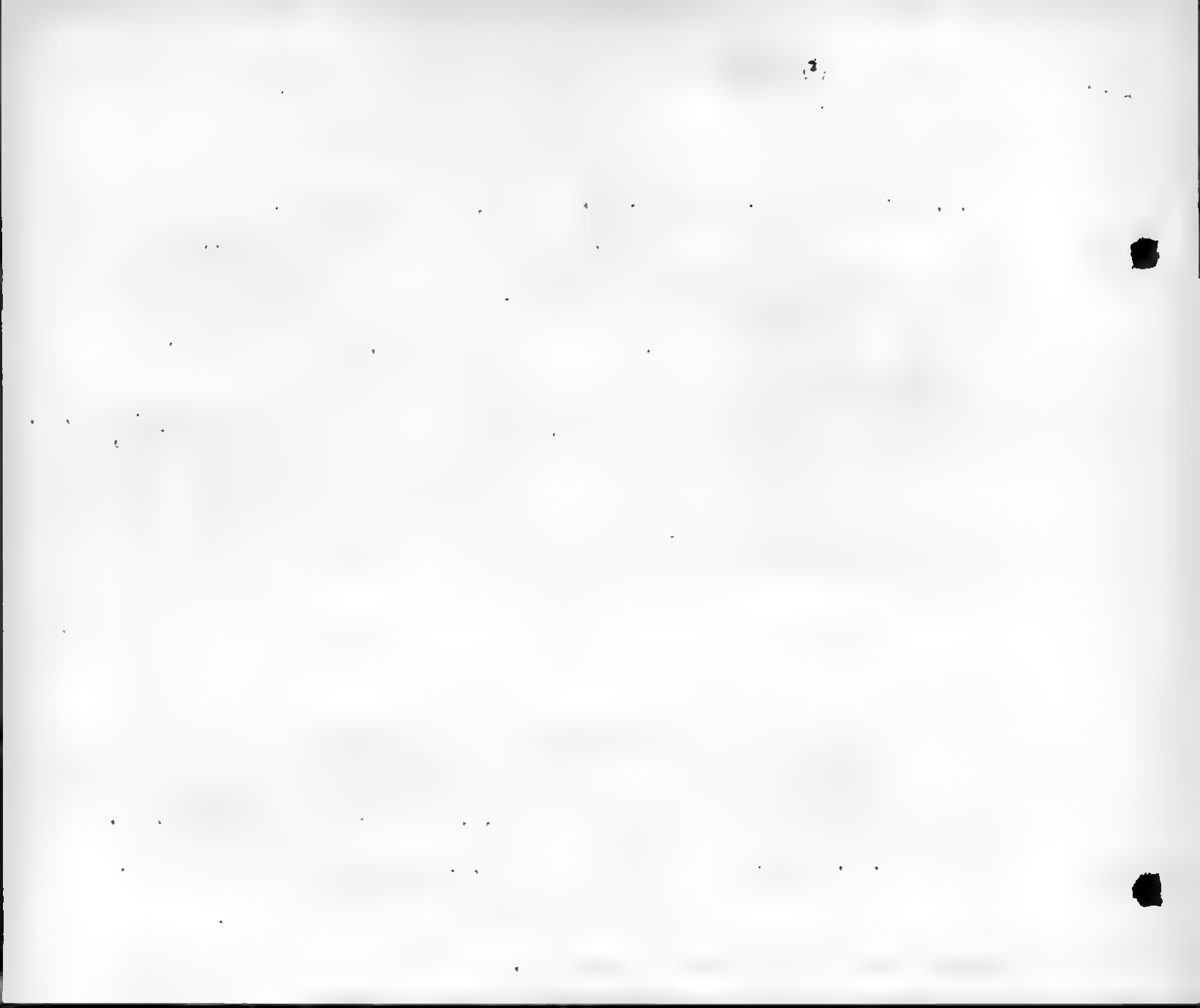
## 3584 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Indian Head</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. STREET ADDRESS <b>Apt. 22-D Riverview St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Denise</b> Middle <b>Marie</b> Last <b>KAISER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3rd</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-59</b>
9. AGE (In years lost birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>3</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Guam, M.I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward John KAISER</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Ann Brodie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Edward John Kaiser APT 22D Riverview</b>		Address <b>Indian Head, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>dehydration, vascular collapse</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>chronic recurrent diarrhea</b> DUE TO (c) <b>refractory to therapy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism and Ventricular septal defect</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 February 19 60</b> to <b>3 March 19 60</b> that I last saw the deceased alive on <b>3 March 19 60</b> and that death occurred at <b>10:45 PM</b> from the causes and on the date stated above ADDRESS (Street, city or town state) <b>U.S. NAVAL HOSPITAL, BETHESDA, Md.</b> DATE SIGNED <b>3-4-60</b>			
ACTUAL SIGNATURE <b>G. B. Avery</b>		M.D. <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>		U.S. NAVAL HOSPITAL, BETHESDA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Transit to Chicago, Ill.</b>		22d. LOCATION (City, town or county) (State) <b>Chicago, Ill.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3443

## CERTIFICATE OF DEATH

03493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING Home</b>		d. STREET ADDRESS <b>600 Sisson St</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>H</b> Last <b>Kalish</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/6 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI CAB DRIVER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ISADORE Kalish</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>SHEILA SHORE-600 SISSON ST 55 Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL Asthma</b> DUE TO <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 24 1960</b> to <b>March 2 1960</b> , that I last saw the deceased alive on <b>March 1 1960</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1019 University Blvd. Ex. Silver Spring Maryland</b> DATE SIGNED <b>3/2/60</b>			
ACTUAL SIGNATURE <b>Boris Ratkin</b>		M.D. <b>1019 University Blvd. Ex. Silver Spring Maryland</b>	
PHYSICIAN'S NAME (Type) <b>BOBIS RATKIN</b>		Silver Spring Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-3-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ELWOOD, L.I. NY</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS</b>		ADDRESS <b>3501-14th St. N.W.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



3585

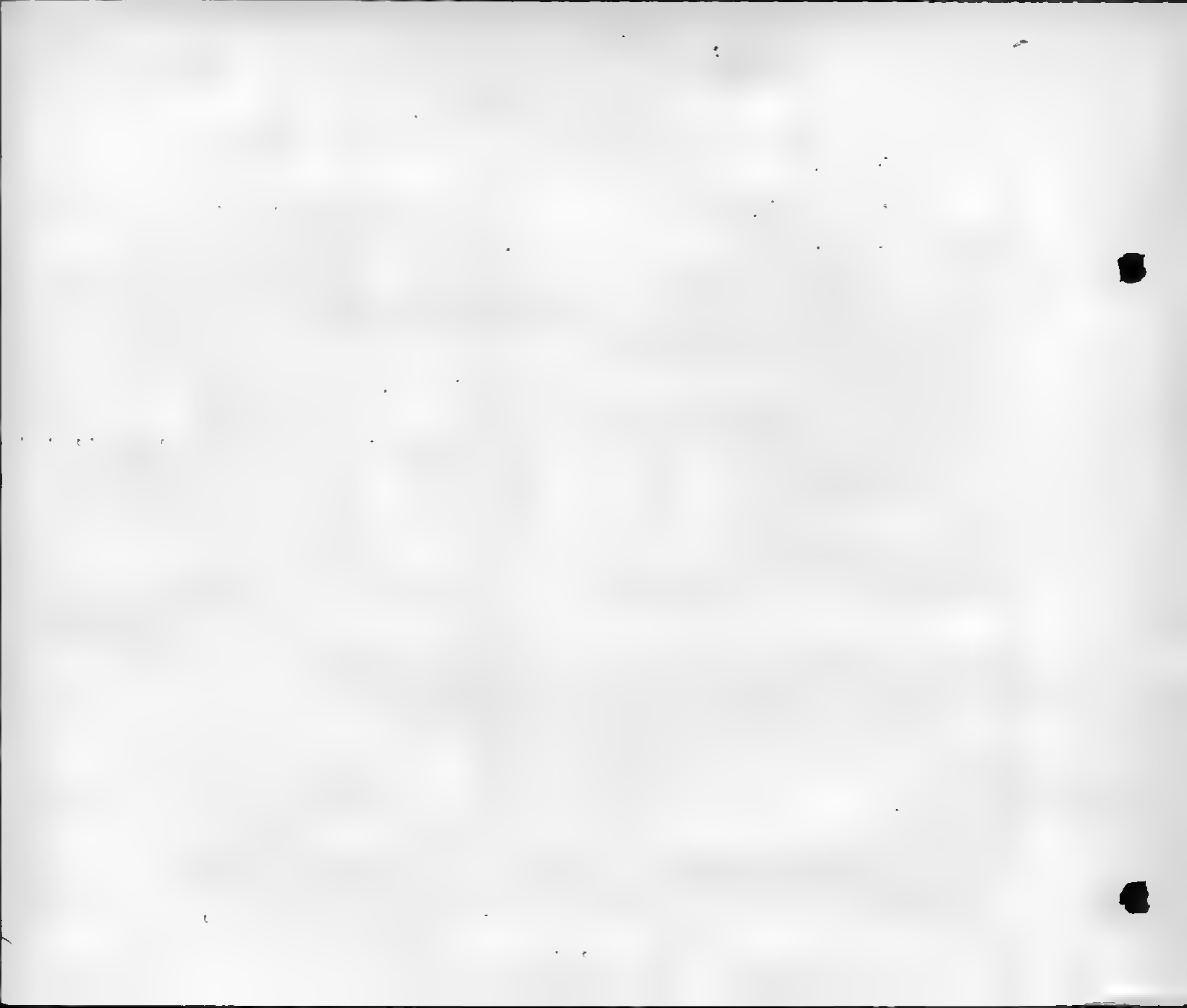
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b> First <b>Karasik</b> Middle <b>Karasik</b> Last		4. DATE OF DEATH <b>3</b> Month <b>10</b> Day <b>1960</b> Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED -- GOV'T. CONSULTANT</b>	
11. BIRTHPLACE (State or foreign country) <b>USSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB KARASIK</b>		14. MOTHER'S MAIDEN NAME <b>FRUMA (?)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b> (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MON O E KARASIK, WOODWARD BLDG., WASH., D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart attack</b> DUE TO <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Left ventricular hypertrophy and atherosclerosis</b> DUE TO <b>Left ventricular hypertrophy and atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>12 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/2/44</b> 19____, to <b>3/10/60</b> 19____, that I last saw the deceased alive on <b>3/10/60</b> 19____, and that death occurred at <b>PPH M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard J. Walsh</b> M.D.		ADDRESS (Street, city or town, state) <b>900-1 1st St. S.W. Wash. D.C.</b> DATE SIGNED <b>3/10/60</b>	
PHYSICIAN'S NAME (Type) <b>Bernard J. Walsh</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>THE NEW MT. CAMEL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BROOKLYN, NEW YORK</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawley</b> ADDRESS <b>1756 PA. AVE., N.W. DC</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3586

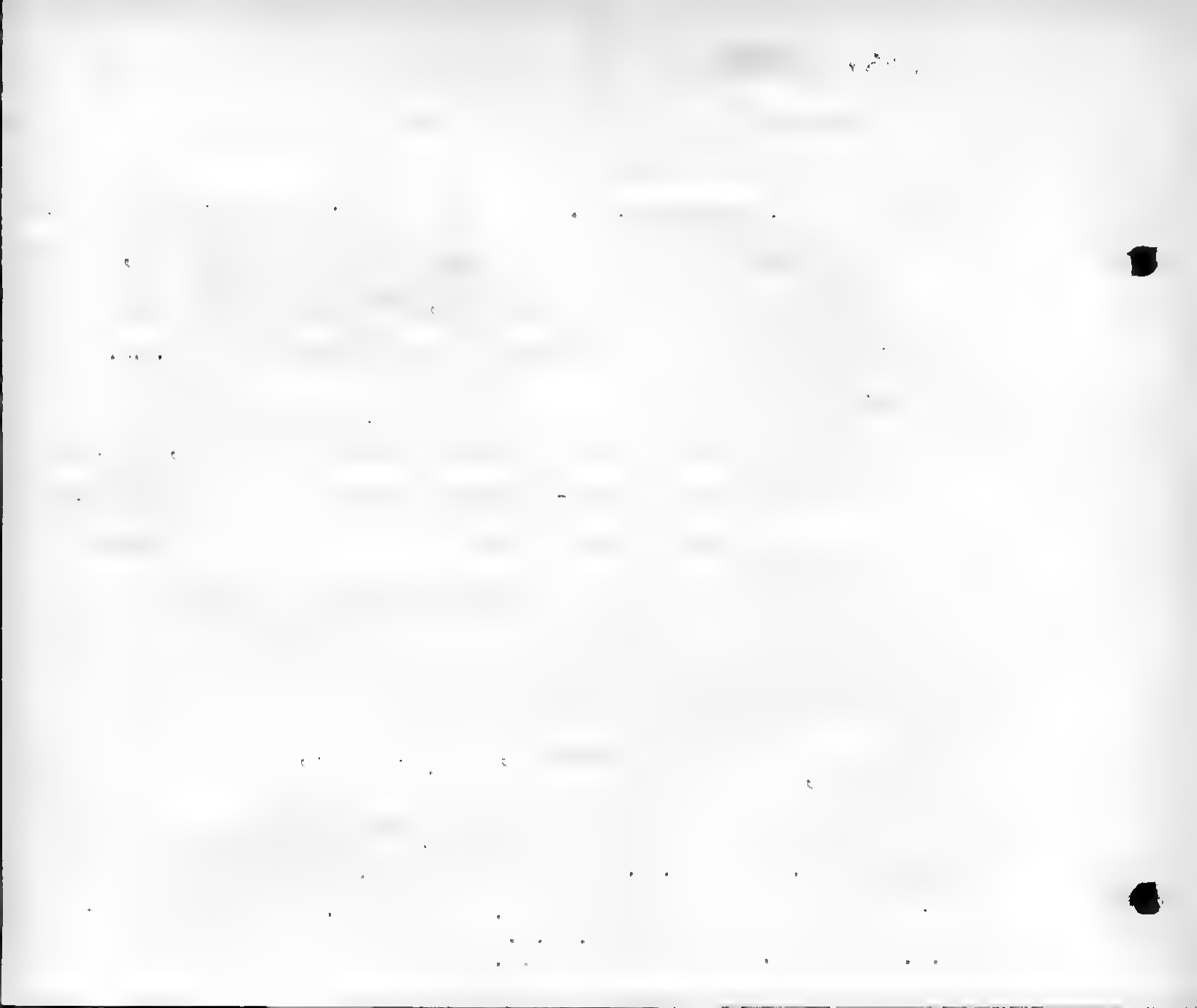
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If inst tut on. Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shenandoah</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>415 West New York Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>Joseph</b> Last <b>Kayes</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1927</b>
9. AGE (In years lost birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dry Cleaner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning (clothes)</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Kayes</b>		14. MOTHER'S MAIDEN NAME <b>Rose Peron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive intra-pulmonary hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 28, 1959</b> to <b>March 20, 1960</b> , that I last saw the deceased alive on <b>March 20, 1960</b> , and that death occurred at <b>1:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/20/60</b> ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>CHARLES E. MENGEL, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>3/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Shenandoah, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3587

## CERTIFICATE OF DEATH

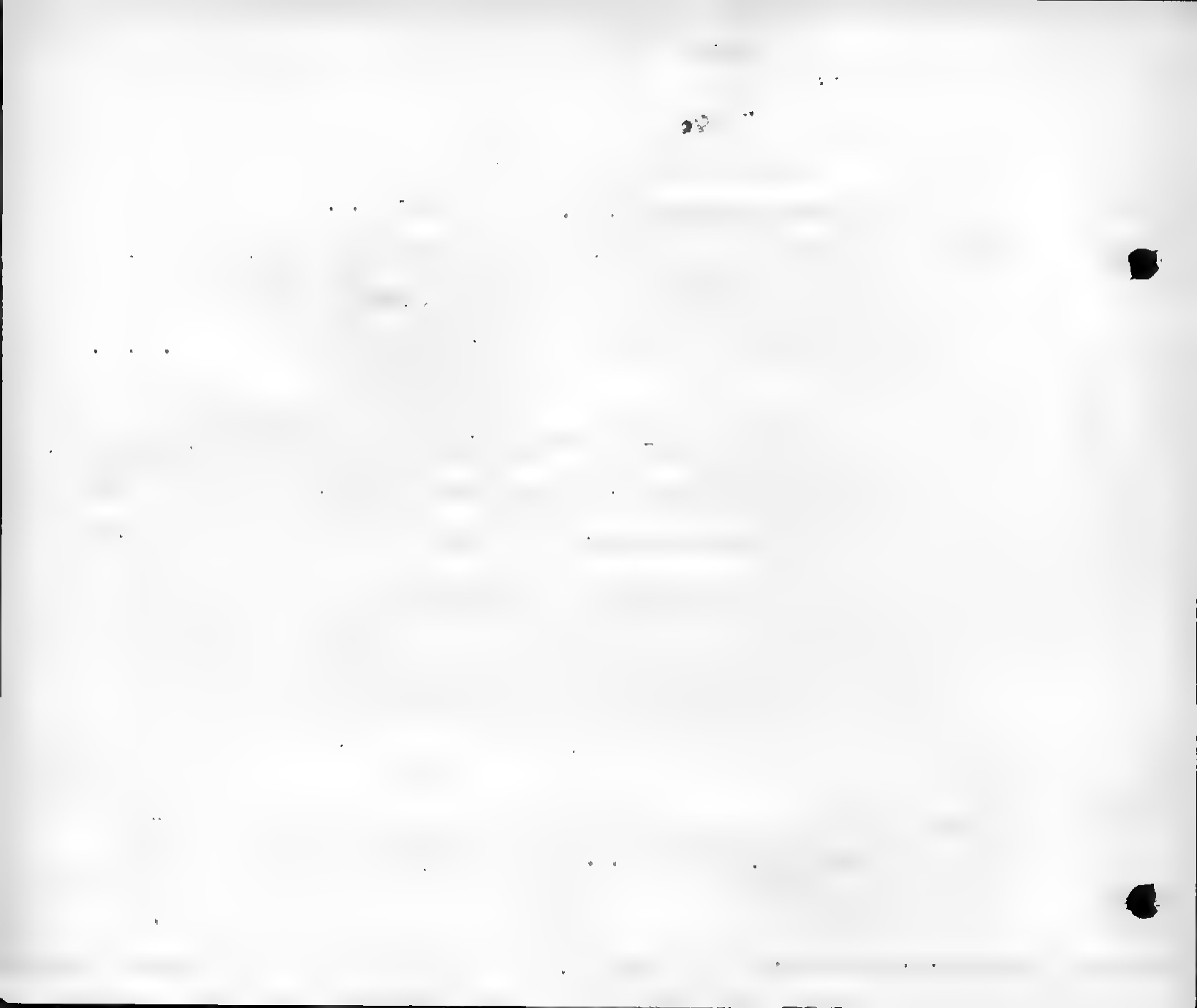
Reg. Dist No.

03502

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>49 days</b>		d. STREET ADDRESS <b>50 F Street, N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Casto</b> Last <b>Keathley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1907</b>
9. AGE (In years lost birthday) yrs. <b>53</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Norman Keathley</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Graham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>412-03-6477</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to Gram Negative Bacillus</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Lymphocytic Leukemia</b> DUE TO (c) <b>Nutritional Cirrhosis with Ascites</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 5, 1960</b> to <b>March 25, 1960</b> , that I last saw the deceased alive on <b>March 25, 1960</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center 3-25-60</b>	
PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>		DATE SIGNED <b>National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

m retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





344

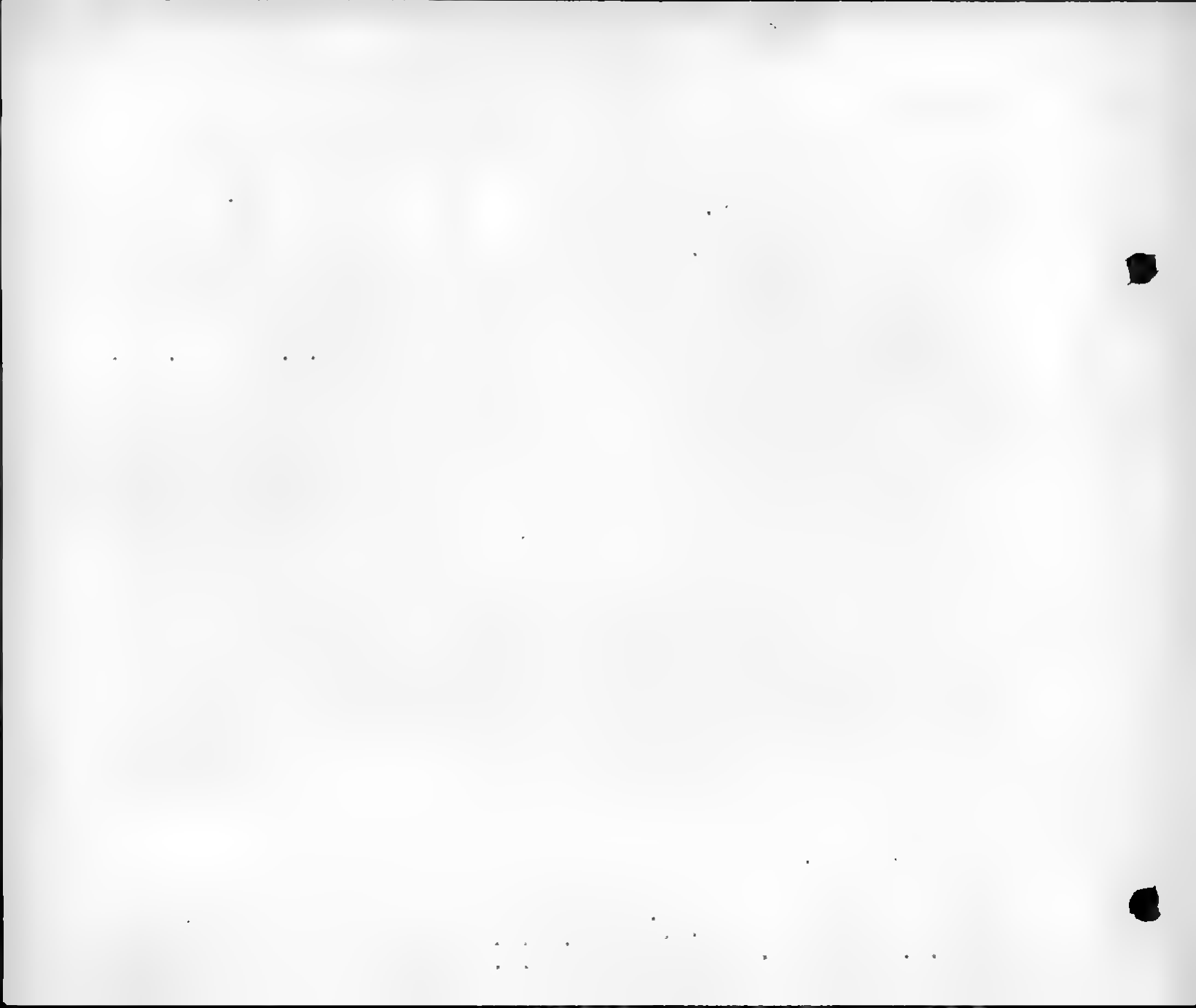
CERTIFICATE OF DEATH

Reg. Dist. No.

03503

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>14511 Colesville Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Riverdale</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1115</b> d. STREET ADDRESS <b>6120 Baltimore Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Irene A. King</b>		4. DATE OF DEATH Month Day Year <b>March 6, 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/70</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lippard</b>		14. MOTHER'S MAIDEN NAME <b>Eldrana Hopkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Self</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Generalized extracranial disease</b> DUE TO (c) <b>3 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-14</b> , 19 <b>52</b> , to <b>3-1</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2-29</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1919 Cemetery Rd. Silver Spring, Md. March 6, 1960</b>			
ACTUAL SIGNATURE <b>John S. Rogers</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>John S. Rogers</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>MAY 4 1960</b>	
24b. REGISTERAR'S SIGNATURE <b>2901 14th St. N.W. Washington 9, D.C.</b>			

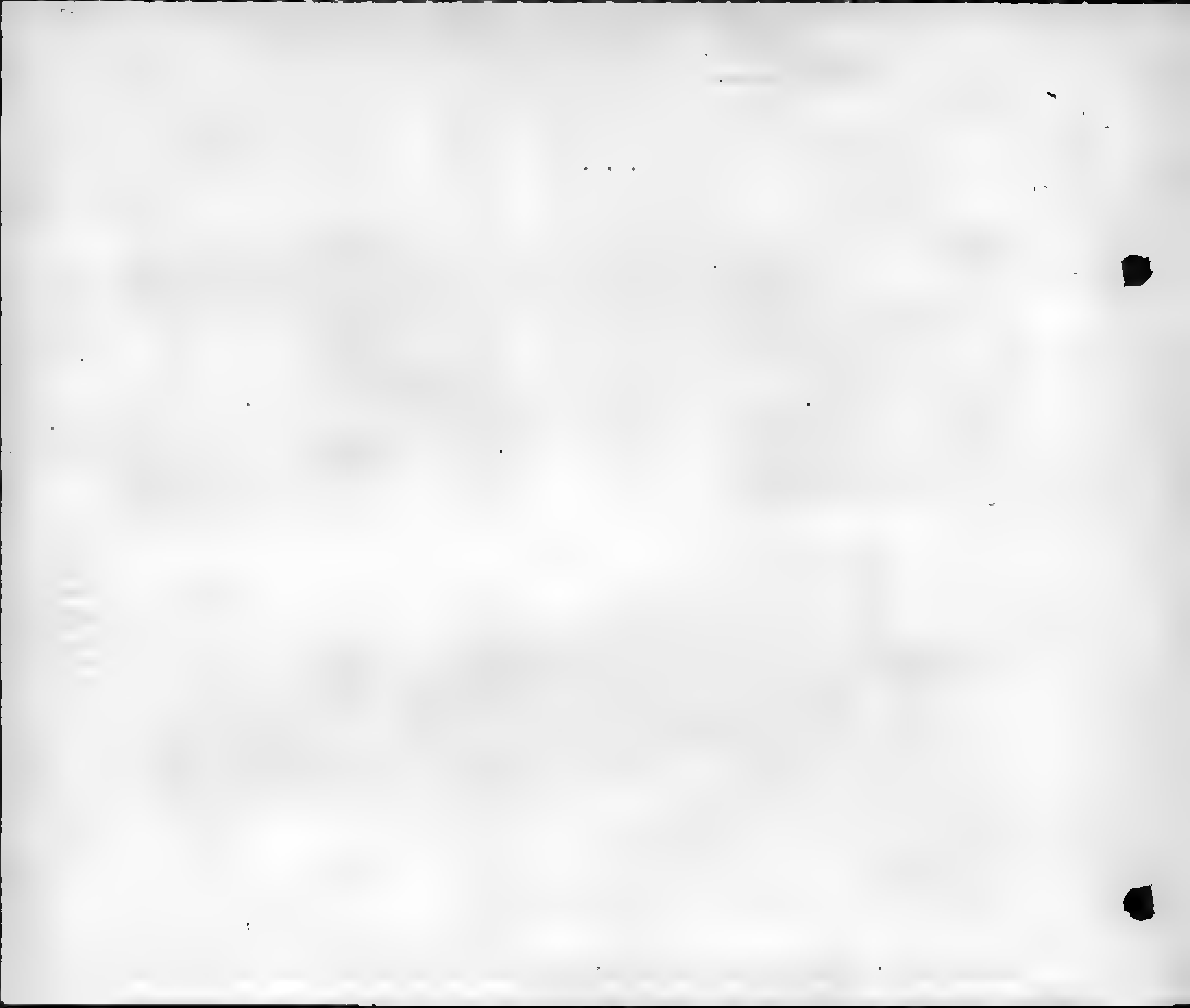
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the delay in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for your files. Forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

Item 20 File 2000											
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
3588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 03504											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>L.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>5006 Wilmett Dr</u>						
3. NAME OF DECEASED (Type or print) First <u>Label</u> Middle <u>D</u> Last <u>Knox</u>					4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1960</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/2 3/16/</u>		9. AGE (In years last birthday) <u>60</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>William B. Dunford</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Kah.</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Chiswell-daughter- Gaithersburg Md</u> Address <u>106 Tulip Dr.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon-monoxide poisoning</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Not determined</u>										INTERVAL BETWEEN ONSET AND DEATH <u>And died in hospital at home</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Not determined</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>-- 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>		20f. (City or town) <u>--</u>		20g. (County) <u>--</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>					ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		



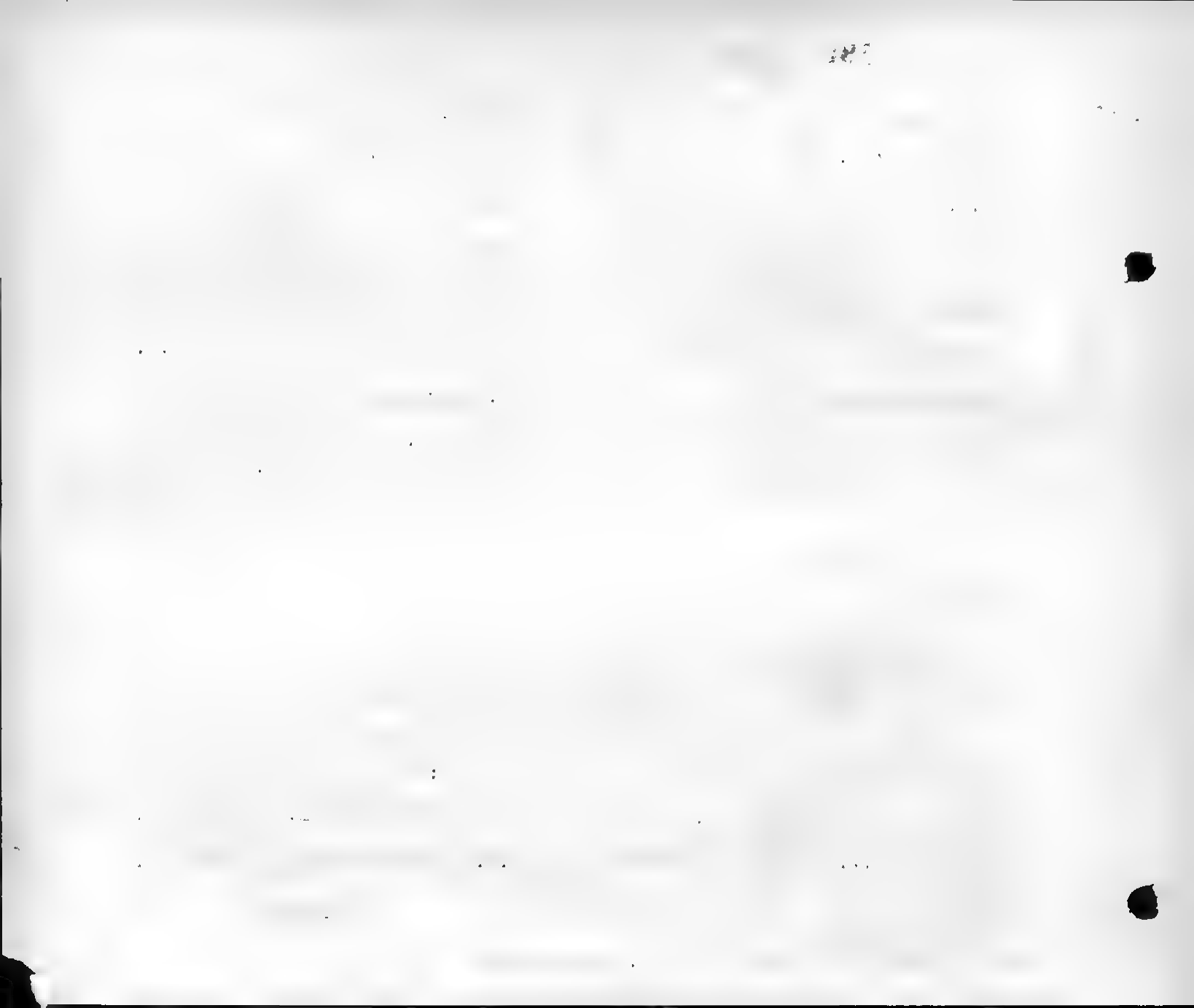
3589

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institut an: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>7</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>236</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>			
				d. STREET ADDRESS <b>Rural Route #1 Box 185</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Mary KOSKY</b>				4. DATE OF DEATH Month Day Year <b>March 7 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-20-84</b>	
				9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Joseph Olzinski</b>				14. MOTHER'S MAIDEN NAME <b>S. Twaragowska</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>(Son) David J. Kosky</b>			
17. ADDRESS <b>Same as #2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intractable congestive Cardiac failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>months</b> DUE TO (c) <b>months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>15 July 1959</b> , to <b>7 March 1960</b> , that I last saw the deceased alive on <b>7 March 1960</b> , and that death occurred at <b>2:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>3-7-60</b>							
ACTUAL SIGNATURE <b>Kenneth V. Harshman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>K.V. HARSHMAN LT MC USN</b>				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Columbus Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b> ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

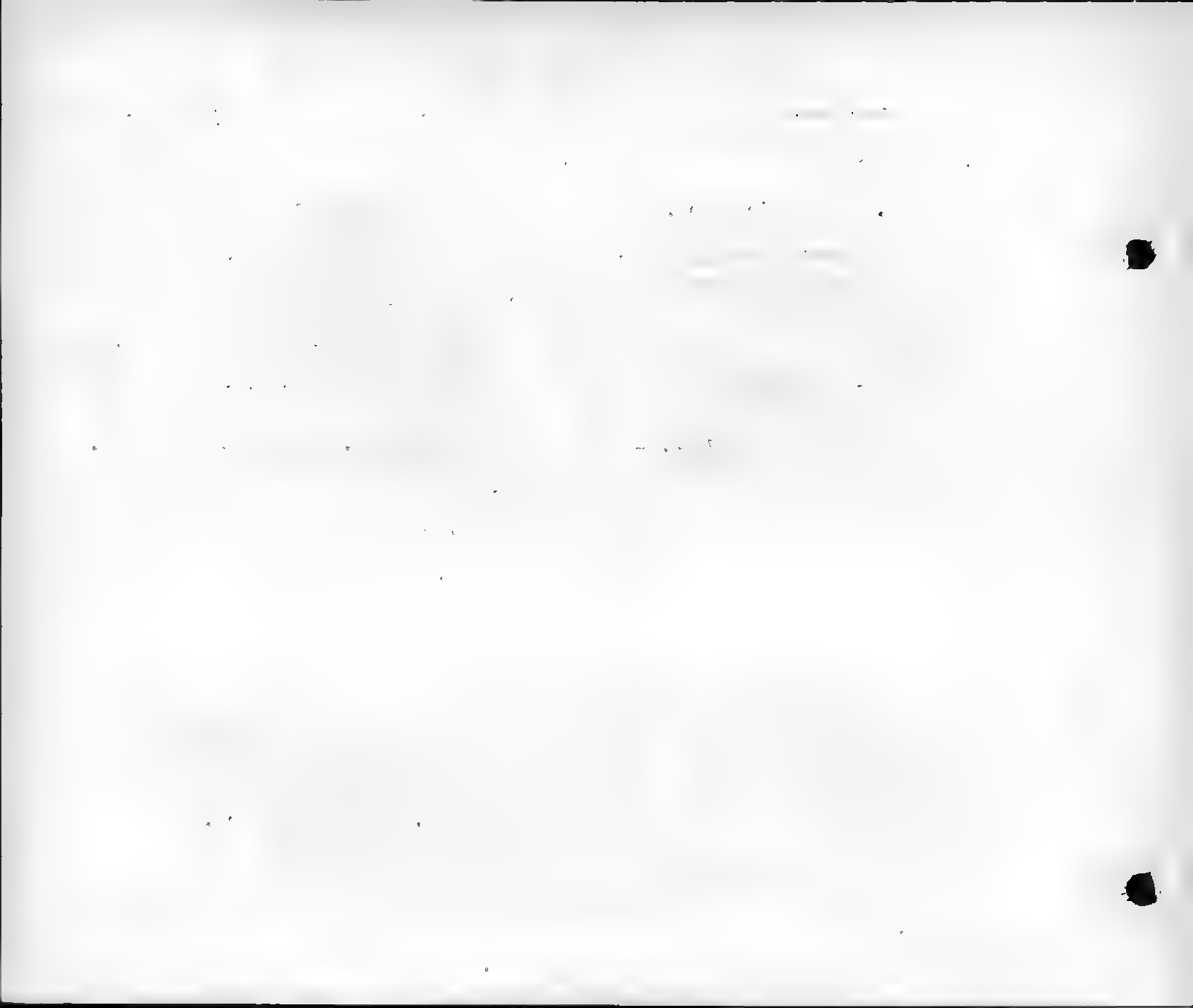
03506

3505

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Hillsborough</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>6 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 N. Frederick Ave.</b>				d. STREET ADDRESS <b>209 South Brevard</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Rheinolt</b> Last <b>Kreklau</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 25, 1892</b>	
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>00</b> M n		11. AGE (In years last birthday) <b>67</b>		12. IF UNDER 24 HRS Months <b>6</b> Days <b>15</b> Hours <b>00</b> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>			
11. BIRTHPLACE (State or foreign country) <b>Chippewa Falls, Wisc.</b>				12. CITIZEN OF WHAT COUNTRY? <b>American</b>			
13. FATHER'S NAME <b>Julius Frank Kreklau</b>				14. MOTHER'S MAIDEN NAME <b>Luisa Marie Marquardt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>W W I</b>				16. SOCIAL SECURITY NO <b>516-09-3190</b>			
17. INFORMANT <b>Julius Kreklau, Gaithersburg, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b>							
157X DUE TO <b>Carcinoma of Liver</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Carcinoma of Pancreas</b>							
DUE TO <b>6 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November</b> , 19 <b>59</b> , to <b>March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>60</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Luciano I. Leal</b>				ADDRESS (Street, city or town, state) <b>108 N. Frederick Ave.</b>			
PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b>				DATE SIGNED <b>Gaithersburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2, 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Missoula Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Missoula, Montana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Gaitersburg</b>				ADDRESS <b>Gaithersburg, Md.</b>			
24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Clifford J. Hume</b>			





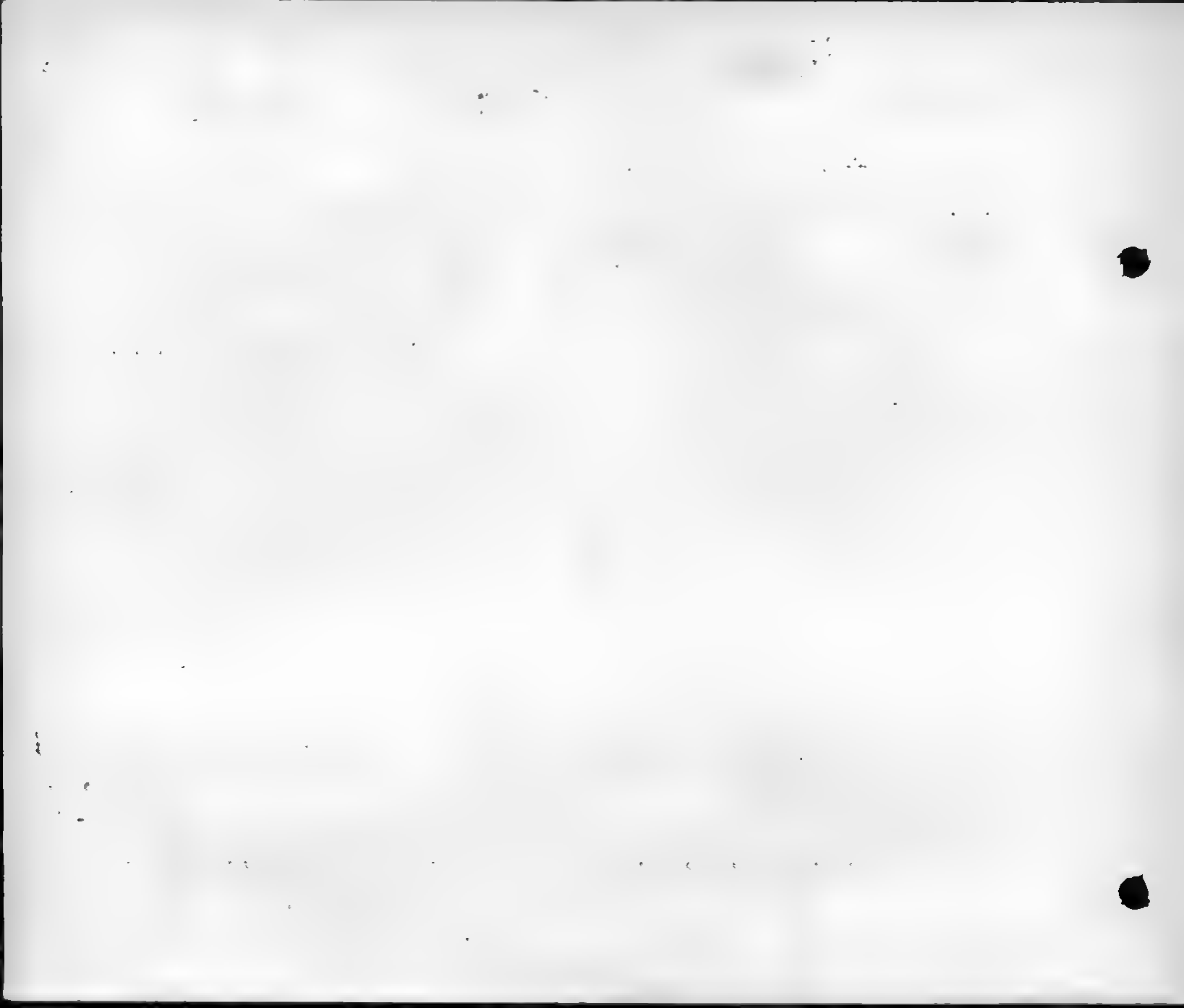
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3590 CERTIFICATE OF DEATH

03507

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>524 Brisbain Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>David Wayne KYLE</b>		4. DATE OF DEATH Month Day Year <b>March 25 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-59</b>
9. AGE (In years last birthday) yrs. <b>3</b> Months <b>18</b> Days <b>18</b> Hours <b>Min</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David C. KYLE</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. STEWART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, septicemia</b> 751x DUE TO (b) <b>hydrocephalus, meningitis - myelocic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day from birth</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>the hospital</del> attended the deceased from <b>March 19 19 60</b> , to <b>March 25 19 60</b> , that (I) <del>the</del> last saw the deceased alive on <b>March 25 19 60</b> , and that death occurred at <b>6 P M</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>G. B. Avery</b>		22b. DATE SIGNED <b>3-26-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25a. REC'D BY REGISTRAR <b>Witzke Funeral Home, 4101 Edmonson Ave. Baltimore</b>		25b. REGISTRAR'S SIGNATURE <b>Witzke</b>	
DATE <b>MAR 29 '60</b>			



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

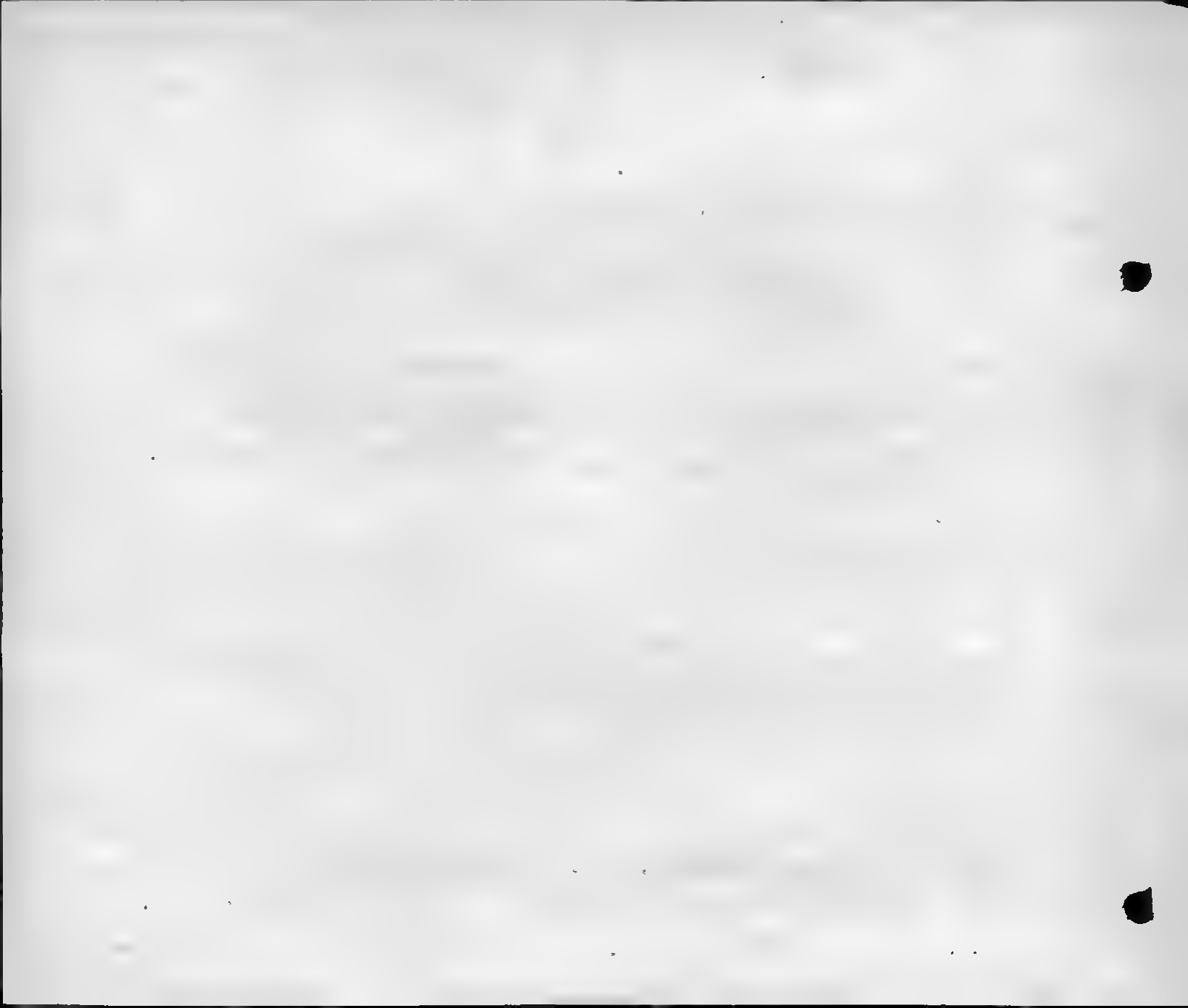
3594

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

19508

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN b <b>4 HRS.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>			b. COUNTY <b>HOWARD</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAYTON</b>			d. STREET ADDRESS			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>JOHN LUE LAMONTE</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1960</b>			5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8/18/58</b>			9. AGE (In years last birthday) <b>1</b> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. NAME OF DECEASED (Type or print) <b>JOHN LUE LAMONTE</b>			14. MOTHER'S MAIDEN NAME <b>HILDA JEANETTE CHAPMAN</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>HOSPITAL RECORDS</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of Kerosene from stomach</b> DUE TO (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 hr</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Child drank Kerosene at home</b>			20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> e.m. <b>3-19-60</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			20f. (City or town) (County) (State) <b>Dayton Howard Md</b>			21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>March 22, 1960</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Dover Cemetery</b>			22d. LOCATION (City, town, or country) (State) <b>Near Reisterstown, Md.</b>		
23. FUNERAL DIRECTOR <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			24a. REC'D BY REGISTRAR <b>MAR 23 60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			24c. DATE			24d. DATE SIGNED <b>3-19-60</b>			24e. ADDRESS (Street, city, town, or county)			24f. ADDRESS (Street, city, town, or county)														



3592

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Clay Late</u>				4. DATE OF DEATH Month Day Year <u>March 1, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-02</u>	9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George F. Late</u>				14. MOTHER'S MAIDEN NAME <u>Allie Putman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1943-1946</u>				16. SOCIAL SECURITY NO. <u>53 01 9219</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>150X</u> DUE TO <u>Postop Status (4 day postop) Resection of Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Agonous Carcinoma of Esophagus</u> DUE TO <u>1 year +</u> (b) <u>Agonous Carcinoma of Esophagus</u> (c) <u>1 year +</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>150X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-19-</u> 19 <u>60</u> , to <u>3-1-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>2-1-</u> 19 <u>60</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph W. Peabody, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>8512 Oak Georgetown Road</u>			
PHYSICIAN'S NAME (Type) <u>Joseph W. Peabody, Jr.</u>				DATE SIGNED <u>Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>				22b. DATE THEREOF <u>3/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> <u>2901 Adelphi St. N.W.</u> <u>Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>MAR 3 1960</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**CITY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

352

(3598)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res: deceased before adm ss on) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3101 McComas Ave</u>		d. STREET ADDRESS <u>3101 McComas Ave</u>	
3. NAME OF DECEASED (Type or print) <u>James Hefty Leach</u>		4. DATE OF DEATH <u>Mar 14 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>M-S-C</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>M-S-C</u>	
13. FATHER'S NAME <u>Frank Leach</u>		14. MOTHER'S MAIDEN NAME <u>Eva Dougherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW #2</u>		16. SOCIAL SECURITY NO <u>469-10-2303</u>	
17. INFORMANT <u>Violet Leach (wife)</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Choking</u> DUE TO (c) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in beams of his home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7</u> p.m. <u>  </u> <u>3-14-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Kensington Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bluscher</u>		DATE SIGNED <u>3-14-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHER</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

VS. A15ME  
SM 7/59



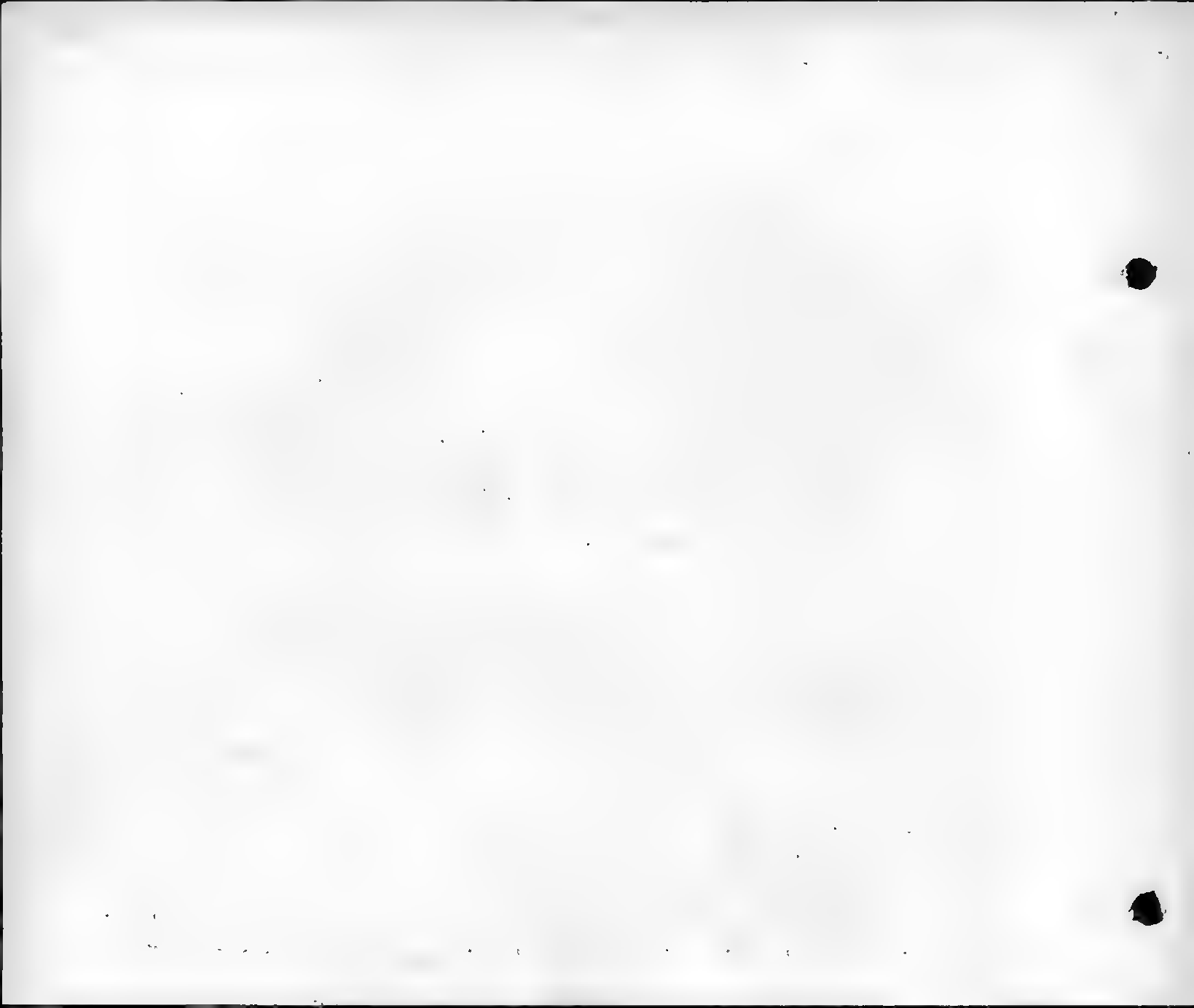


3476

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SANITARIUM + Hospital</b>		d. STREET ADDRESS <b>1414 SILVER SPRING</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE VIRGINIA LECHLIDER</b>		4. DATE OF DEATH Month <b>3</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-'90</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.S. W. fr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>COLESVILLE Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HERBERT J.T. RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>ALICE VAN HORN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Silver Spring, Md.</b>	
17. MRS Egneta Schulze - 412 Silver Spring Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> 43211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 13</b> , 19 <b>52</b> , to <b>May 2</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 25</b> , 19 <b>60</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Aaron H. Traum M.D.</b>		ADDRESS (Street, city or town, state) <b>P237 George Ave Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>AARON H. TRAUM</b>		DATE SIGNED <b>3/2/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/5/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE UNION CEMETERY</b>		22d. LOCATION (City town or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAR 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

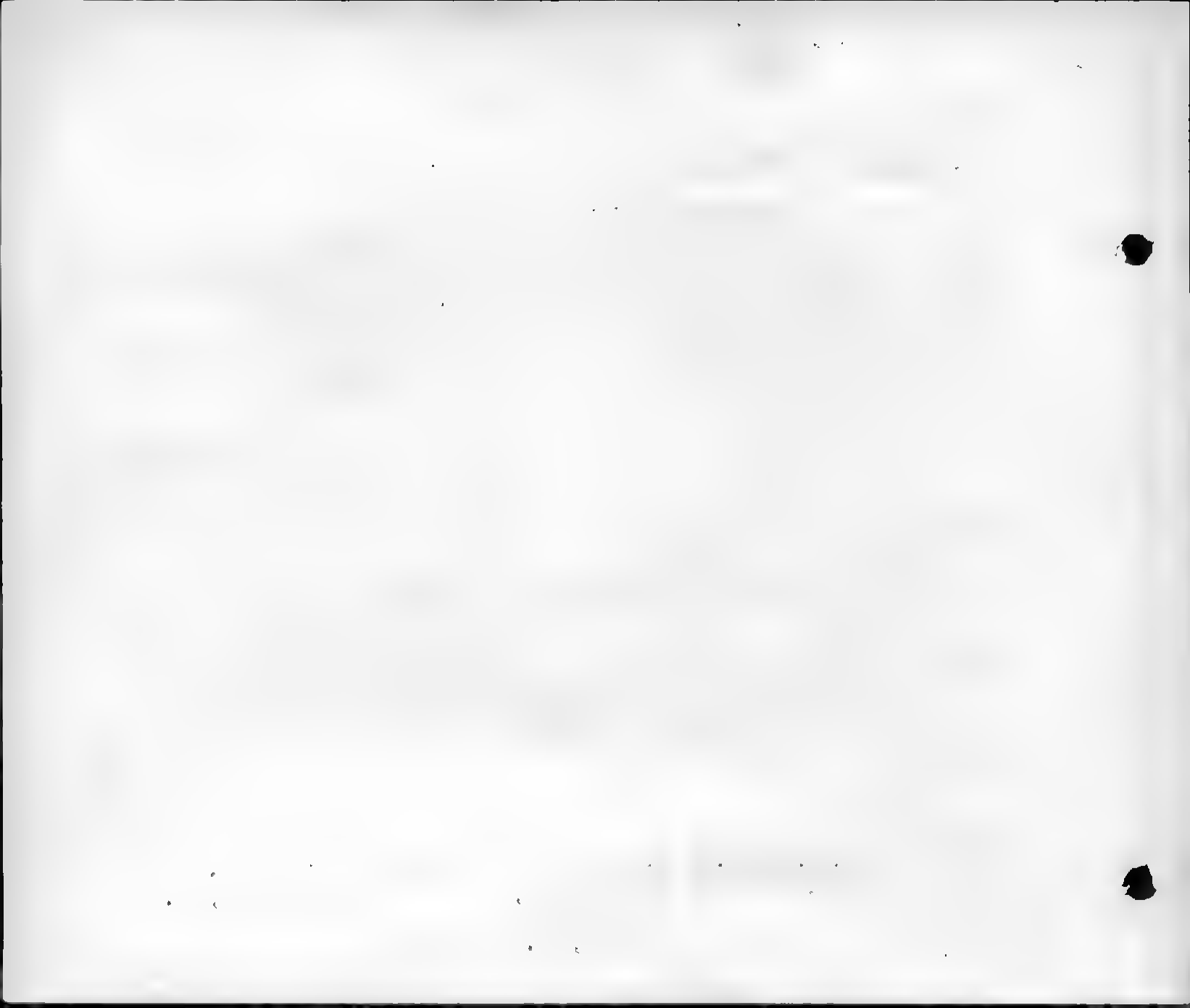
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3593  
CERTIFICATE OF DEATH

03511

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring Olhey</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring</b> d. STREET ADDRESS <b>Chandlee Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Wilson Lee</b>		4. DATE OF DEATH Month Day Year <b>March 15, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1927</b>
9. AGE (In years lost birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Wilson Lee</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>17 - Bronchopneumonia</b> DUE TO <b>Androblastoma of testicle, left - metastatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>12/7 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/7 1959</b> to <b>3/15 1960</b> , that (I) (we) last saw the deceased alive on <b>3/15 1960</b> , and that death occurred on <b>3/15 1960</b> at <b>8:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Ligon</b>		22b. DATE SIGNED <b>3/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M. D.</b>		22d. ADDRESS <b>Sandy Spring, Md.</b>	
23a. BURIAL CREMATION REMOVED (Type) <b>Buried</b>		23b. DATE THEREOF <b>3/19/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial,</b>		23d. LOCATION (City town or county) (State) <b>Sandy Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert S. Smith</b>		ADDRESS <b>Rockville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>MAR 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	



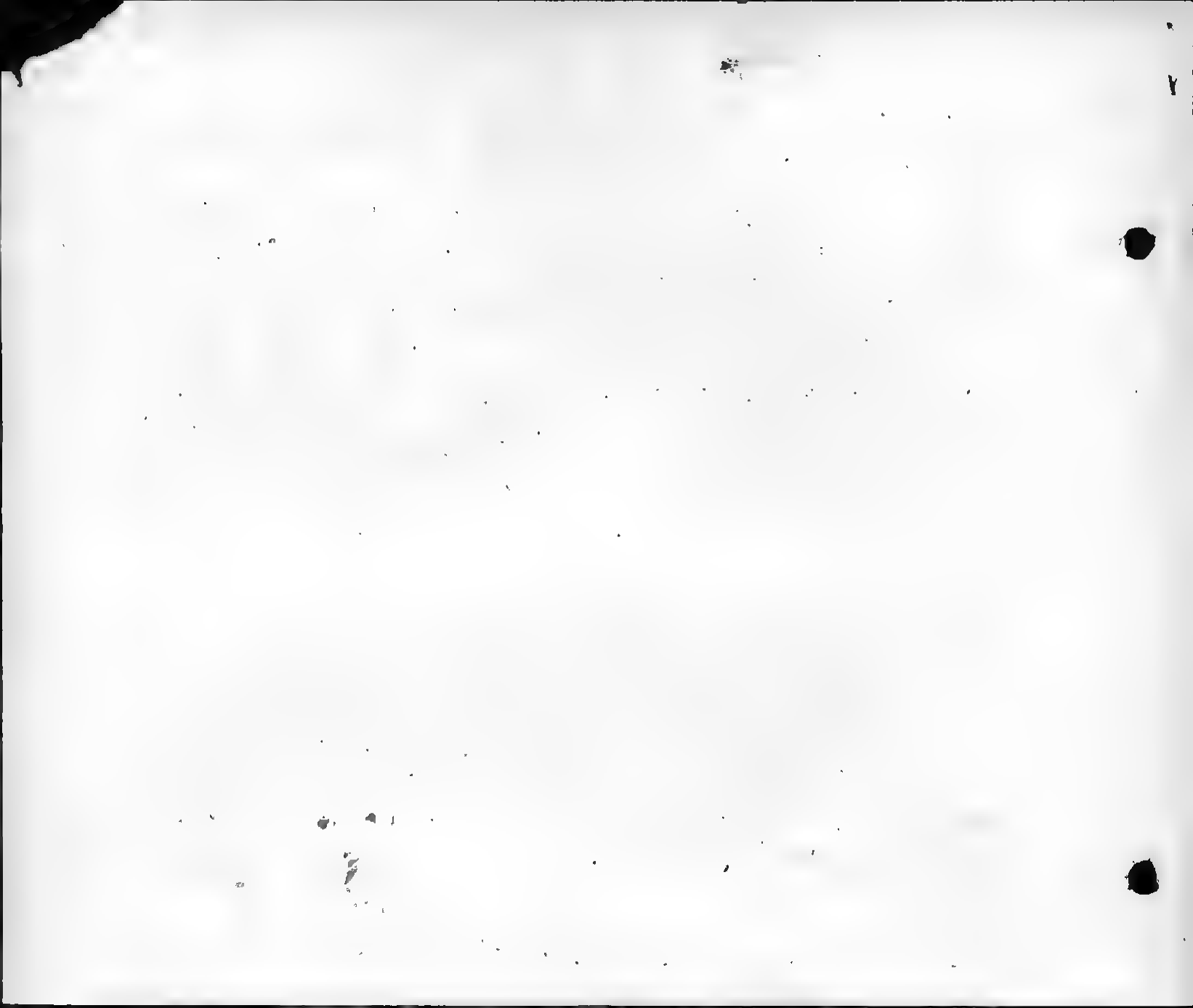
3594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hosp</u>		d. STREET ADDRESS <u>3629- EVERETT ST NW</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE</u> <u>LIDOFF</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>10</u> <u>1960</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9-1890</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SAMUEL ROSENBERG</u>	
14. MOTHER'S MAIDEN NAME <u>NETTIE NILENSKI</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>—</u>		INFORMANT Address <u>9103</u> <u>Estel Kraiel, daughter Brieley</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1960</u> to <u>March 12, 1960</u> that I last saw the deceased alive on <u>March 3, 1960</u> and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kyrol A Schulman M.D.</u>		ADDRESS (Street, city or town, state) <u>1801 Eggleston St NW Washington, DC</u>	
PHYSICIAN'S NAME (Type) <u>Kyrol A Schulman M.D.</u>		DATE SIGNED <u>3/10/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Cong Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington - DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY &amp; SONS</u>		24. REC'D BY REGISTRAR <u>3501-14 ST NW</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>MAR 15 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3593

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRFAN D</b>				c. LENGTH OF STAY IN Td <b>2/5/60-3/27/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRFAN NURSING Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
f. STREET ADDRESS <b>6406 RUFFIN Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leo</b> Middle <b>G</b> Last <b>Liebschutz</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>78</b> yrs	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Union</b>		11. BIRTHPLACE (State or foreign country) <b>CHIC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SAMUEL LIEBSCHUTZ</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA FOX</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-09-94N</b>		INFORMANT <b>HENRY LIEBSCHUTZ</b> Address <b>Ch Ch Md. 6406 RUFFIN RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the soft palate</b> <b>144X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 59</b> to <b>March 27, 1960</b> , that I last saw the deceased alive on <b>March 27, 1960</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew E. Fischer</b> M.D.				ADDRESS (Street, city or town, state) <b>901 20th St N.W. Washington D.C.</b> DATE SIGNED <b>3-27-60</b>			
PHYSICIAN'S NAME (Type) <b>ANDREW E. FISCHER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON HEBREW Cong. Cem. WASHINGTON</b>		22d. LOCATION (City, town, or county) (State) <b>D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY-SONS</b> ADDRESS <b>3501-14th St. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information obtained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



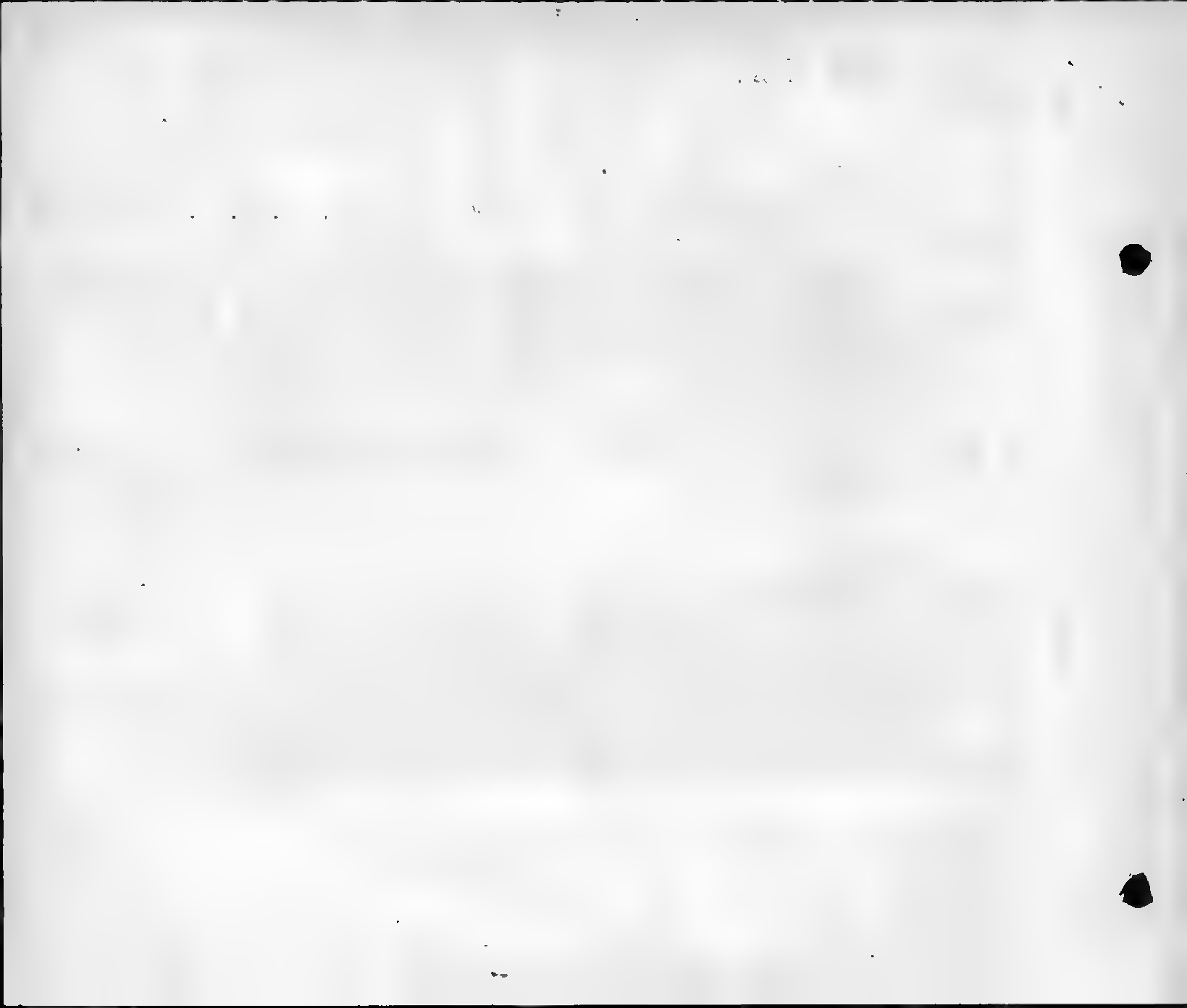


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please explain in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> <del>Atlanta</del> b. COUNTY <u>Fulton</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN TB <u>24 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta</u>			47.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>574 Moreland Ave. N. E.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Dunford</u> Last <u>Littlepage</u>					4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u> <u>May 9, 1889</u>		9. AGE (in years last birthday) <u>70</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>W.B. Dumford</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Kah 1</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>Daughter Mrs. Mitchell Dan ville, Va.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>2.9</u> DUE TO <u>Tension pneumothorax bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon Monoxide Poisoning</u> DUE TO <u>Acute pancreatitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Acute pancreatitis</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>48 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Not determined</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Frank J. Broschank</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschank</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> Bethesda, Maryland					24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

03514

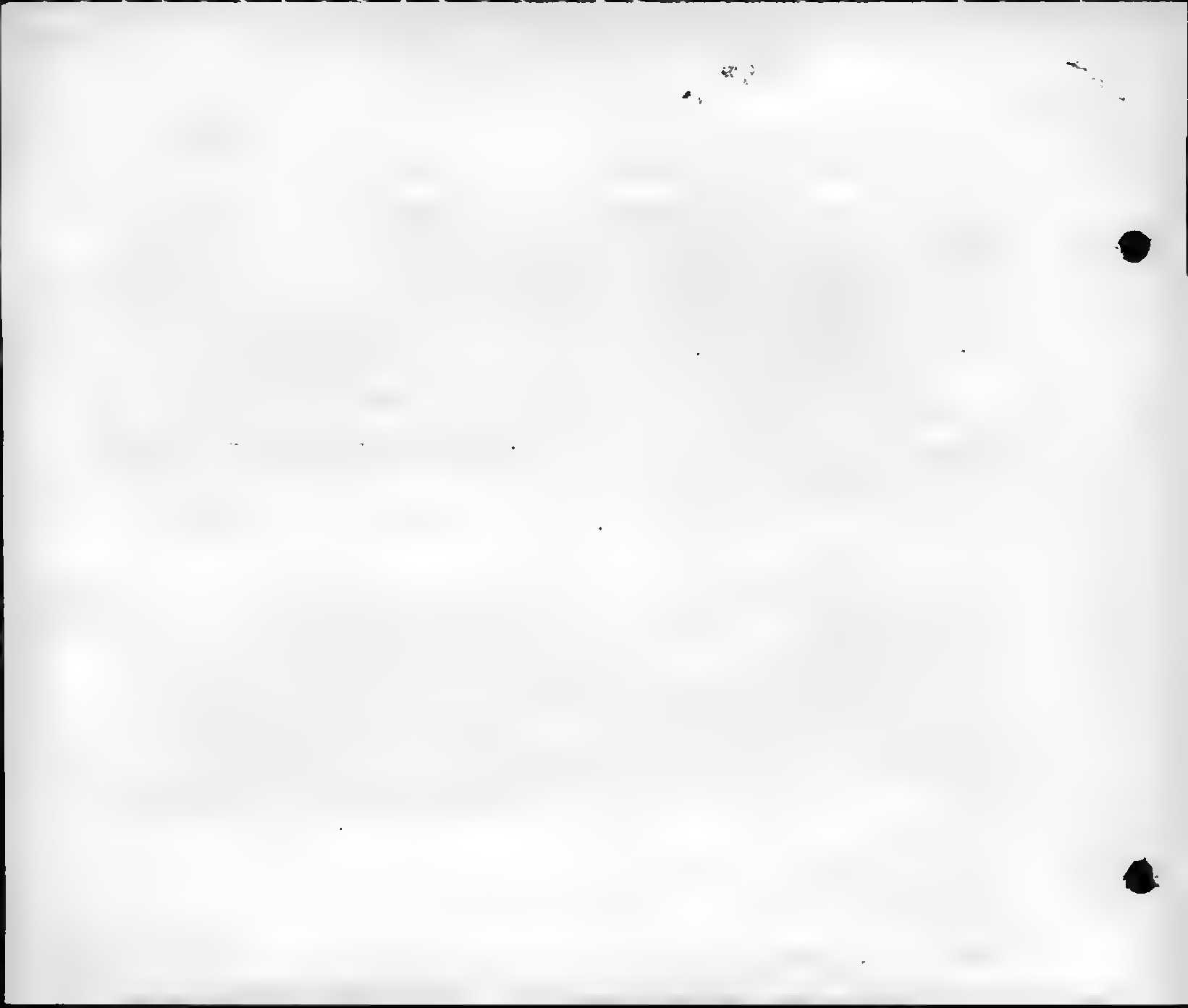


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 22 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**359** **CERTIFICATE OF DEATH**

03515

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>7 years</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5726 Bradley Boulevard</b>				e STREET ADDRESS <b>5726 Bradley Boulevard</b>			
3. NAME OF DECEASED (Type or print) <b>Willard E Lockley</b>				4. DATE OF DEATH <b>March 5 19 60</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/22/82</b>	
9. AGE (n years last birthday) <b>77 yrs</b>		IF UNDER 1 YEAR <b>11 13</b> Months Days		IF UNDER 24 HRS. <b>19 60</b> Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret-Advertising</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Advertising</b>			
11. BIRTHPLACE (State or foreign country) <b>Montana</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>William Lockey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Mrs. Grosvenor-daughter-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Toxic</b>							
DUE TO <b>Carcinoma Rectum</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>March 3 1960</b> to <b>March 5 1960</b> , that (I) (we) last saw the deceased alive on <b>March 5 1960</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm Fleet Lockett</b>				M D ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm Fleet Lockett</b>				22d. ADDRESS <b>5000 Reno Rd NW</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

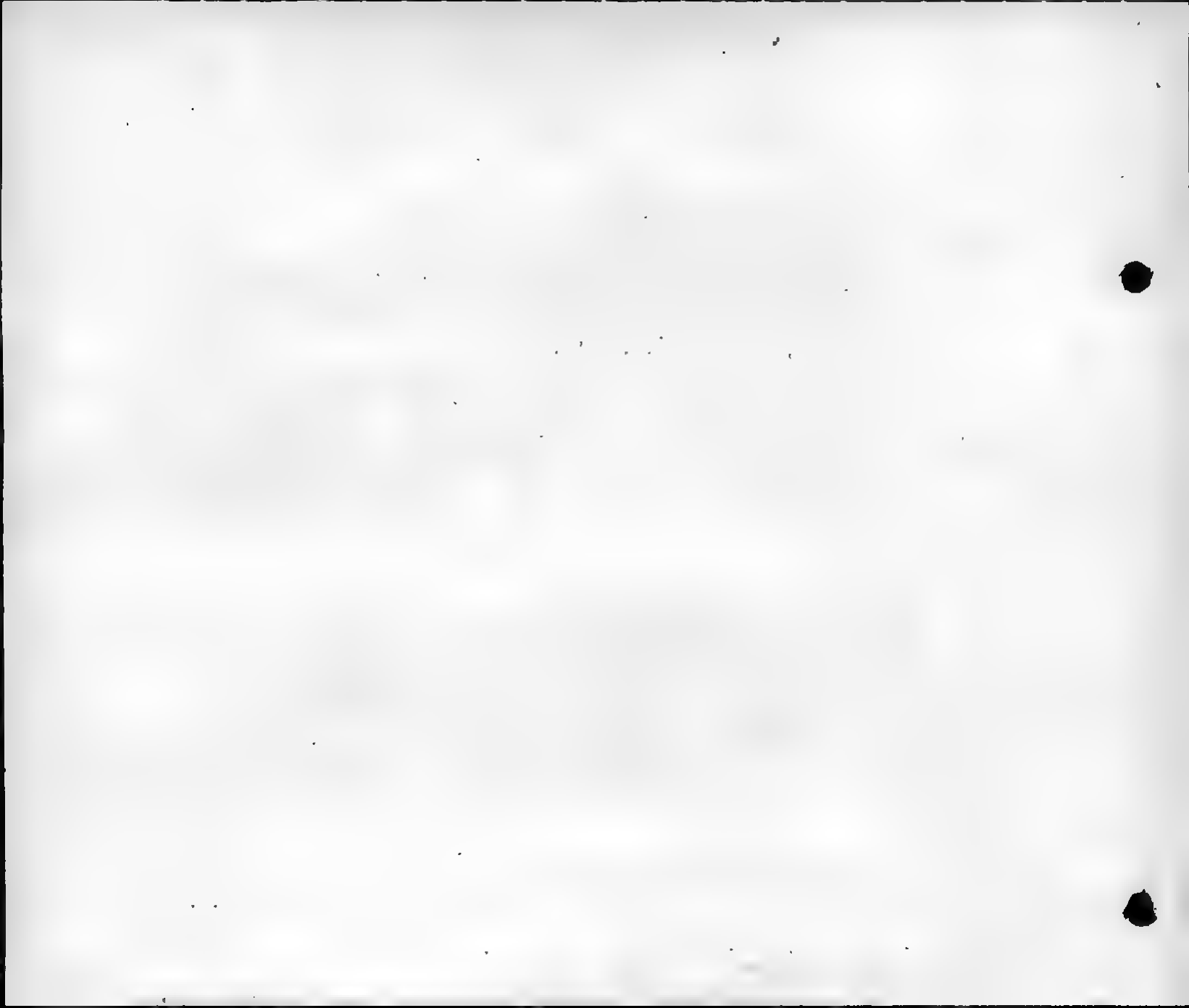


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>1432 Northwest Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Cwen Lambert Lockwood</u>				4. DATE OF DEATH <u>March 24 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/29/83</u>	
9. AGE (In years last birthday) <u>76 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian, Surgeon</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Lockwood</u>				14. MOTHER'S MAIDEN NAME <u>ROSE CALLAHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Dr's hospital Record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure - Myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis - Myocardial anoxia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Esophagus - Post surgical bypass</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>3/20</u> 19 <u>60</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> 19 <u>60</u> , to <u>March 24</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>60</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Marvin L. Lockin</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>MARVIN L. LOCKIN</u> 22d. ADDRESS <u>8485 FENTON ST., S.S., MD.</u> 22b. DATE SIGNED <u>3/24/60</u> 23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3/28/60</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u> 23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u> 25a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u> DATE <u>MAR 28 '60</u> 25b. REGISTRAR'S SIGNATURE <u>O. J. King</u>							



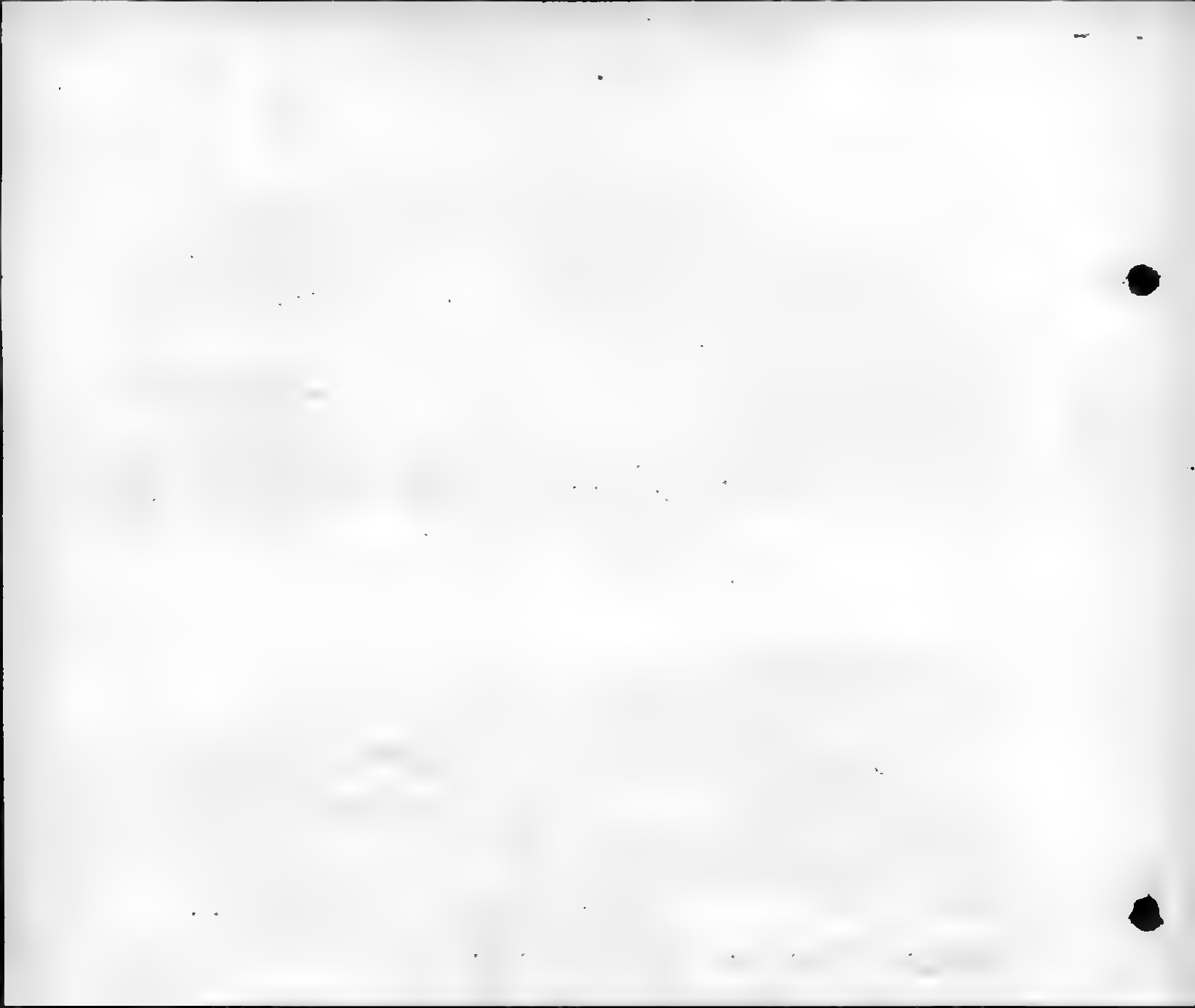
3478

## CERTIFICATE OF DEATH

03517

Reg. Dist. No.

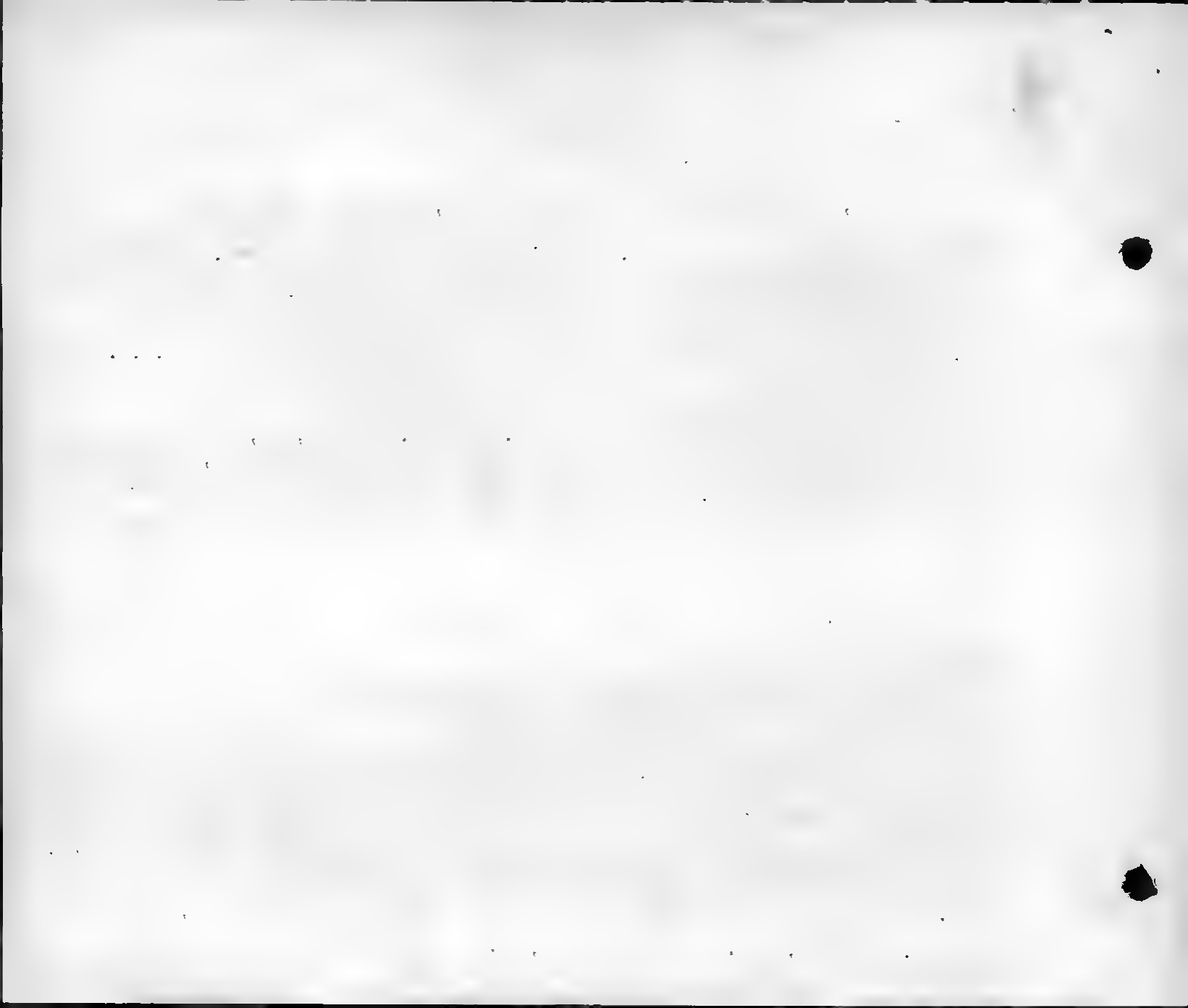
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>432 North West Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Ellen</u> Last <u>Lockwood</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-84</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Stilwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis of pulmonary artery</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>myocardial insufficiency &amp; failure</u> DUE TO (c) <u>hypertensive heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>14 months</u> <u>20 or 34 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 4</u> , 19 <u>55</u> , to <u>Mar 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 4</u> , 19 <u>60</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above. John N. Andrews 9601 Galesville Rd Silver Spring, Md Mar 4 - 1960 John N. Andrews M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		24a. REC'D BY REGISTRAR <u>Mar 9 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Carroll B. Kinn</u>		24c. REGISTRAR'S NAME <u>Carroll B. Kinn</u>	





**3443** **CERTIFICATE OF DEATH**

### MEDICAL CERTIFICATION



3598

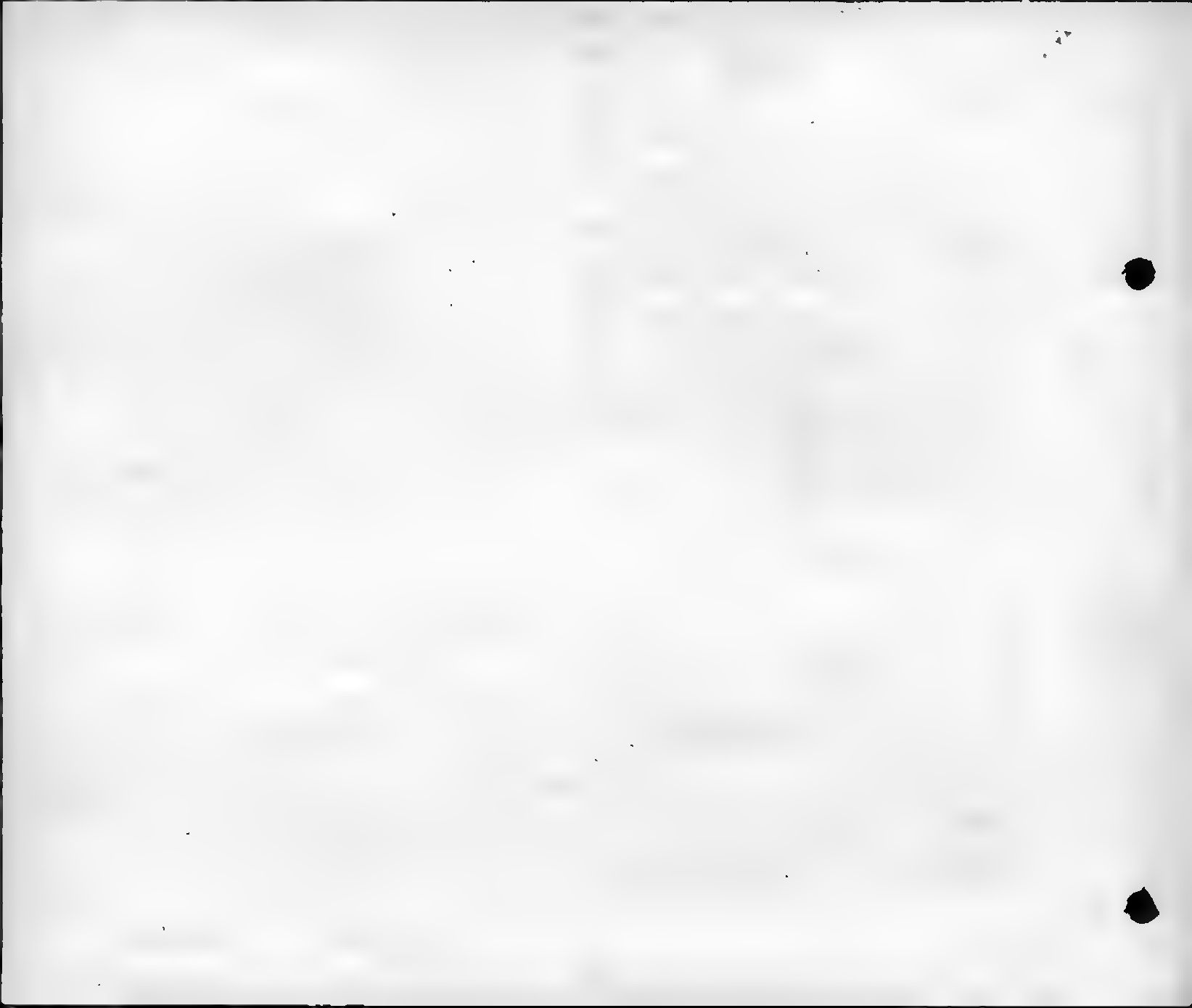
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE CARSON LOWNDEN</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>5</u> Day <u>30</u> Year <u>1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDRE LOWNDEN</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE KERCHEVAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>HOSPITAL RECORDS.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Thrombosis</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic</u> (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>3</u> Day <u>2</u> Year <u>1960</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> to <u>3/2/1960</u> , that I last saw the deceased alive on <u>3/1/1960</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3066 Connecticut Ave. N.W.</u> DATE SIGNED <u>3/2/60</u> ACTUAL SIGNATURE <u>Joseph Lawrence</u> M.D. PHYSICIAN'S NAME (Type) <u>EUSTACE LYDANE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence</u> ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>3066 Connecticut Ave. N.W.</u> DATE <u>MAR 7 1960</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

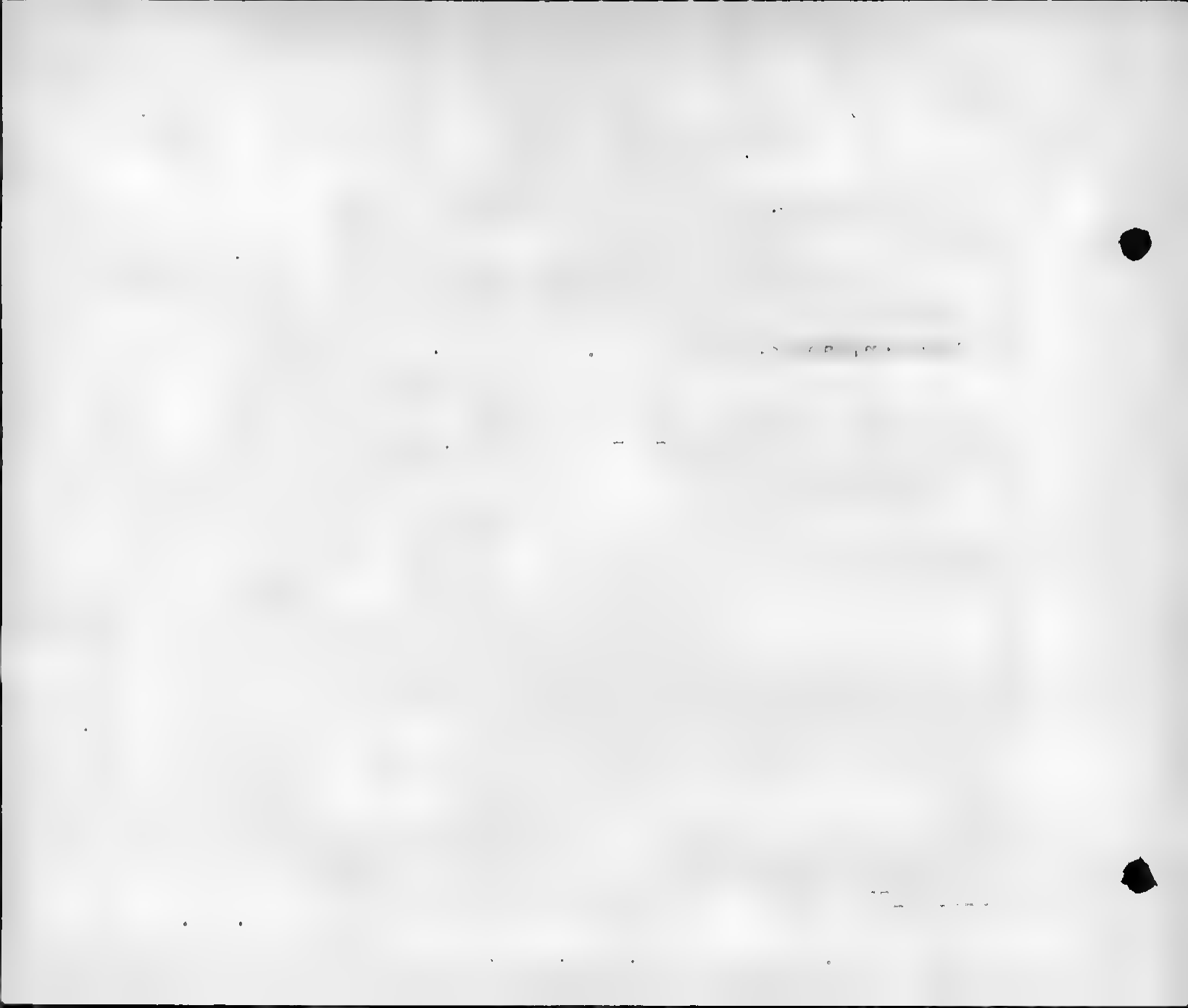


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# 3599 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03520

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Surburban Hosp.</b>				d. STREET ADDRESS <b>13 Hutton St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Young</b> Last <b>Lyles</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>20</b> , Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/26/1909</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life or as retired) <b>Bookkeeper, Capitol</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cooling Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-03-4119</b>		17. INFORMANT <b>Hosp. Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>915... carbon monoxide poisoning</b> DUE TO <b>Smoke inhalation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Smoke inhalation</b> DUE TO <b>Smoke inhalation</b> (c) <b>Smoke inhalation</b>							INTERVA. BETWEEN ONSET AND DEATH <b>sublethal</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found collapsed in burning home</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found collapsed in burning home</b>					
20c. TIME OF INJURY Hour <b>4:00</b> a.m. <input checked="" type="checkbox"/> p.m. <b>3/20</b> 19 <b>60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Gaithersburg</b>		(County) <b>Montg.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL, etc. <b>burial</b>		22b. DATE THEREOF <b>3/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines Co., 2901 14th St. N.W., Wash, DC</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Items 18&21 Film 259 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3600 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 14 Film 259 3-30-60 et

1. PLACE OF DEATH  
a. COUNTY **Montgomery** MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Wheaton Bethesda** c. LENGTH OF STAY IN lb **15 minutes**  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **U.S. Naval Hospital, Bethesda**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Montgomery**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Wheaton**  
d. STREET ADDRESS **11633 Viers Mill Rd**

3. NAME OF DECEASED (Type or print) **Bobby E. Mahaffey** 4. DATE OF DEATH **March 19 1960**  
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **12-26-34** 9. AGE (In years last birthday) **25** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **RMI U.S. Navy** 10b. KIND OF BUSINESS OR INDUSTRY **U.S. Government** 11. BIRTHPLACE (State or foreign country) **New Mexico** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Fred E. Mahaffey** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **Yes 1953-1960** 16. SOCIAL SECURITY NO. **(Official Hospital Records)** 17. INFORMANT Address **(Official Hospital Records)**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE: **Sodium fluoride poisoning**  
971.7 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

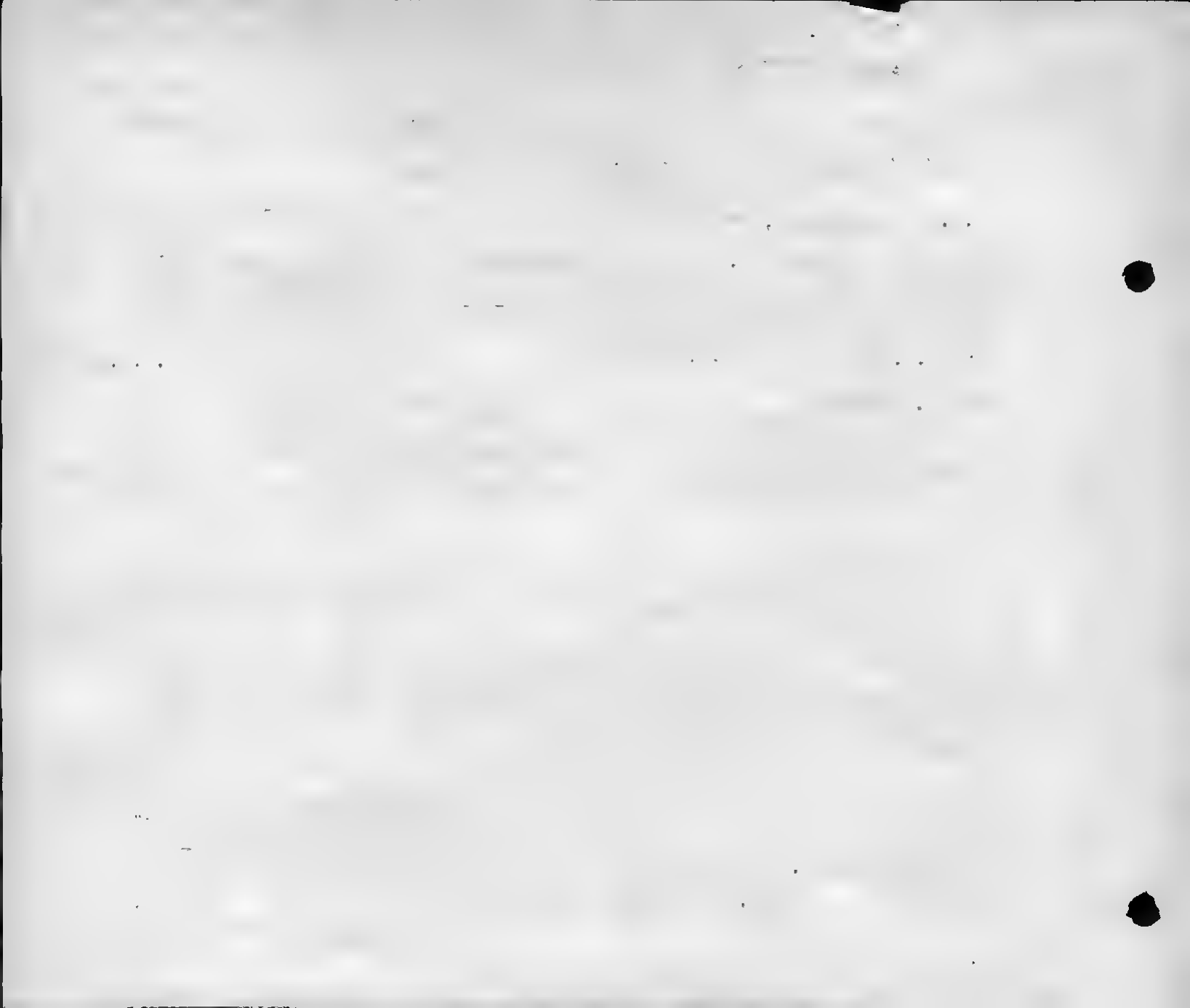
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Frank J. Broschart** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **3-19-60**  
EXAMINER'S NAME (Type) **Frank J. Broschart** Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial - Ship** 22b. DATE THEREOF **March 23 1960** 22c. NAME OF CEMETERY OR CREMATORY **Greenhills Memorial Park** 22d. LOCATION (City, town, or county) (State) **San Pedro California**

23. FUNERAL DIRECTOR **W.W. Chambers** ADDRESS **1400 Caplin Street N.W. Washington D.C.** 24a. REC'D BY REGISTRAR **MAR 24 1960** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

09521





3601

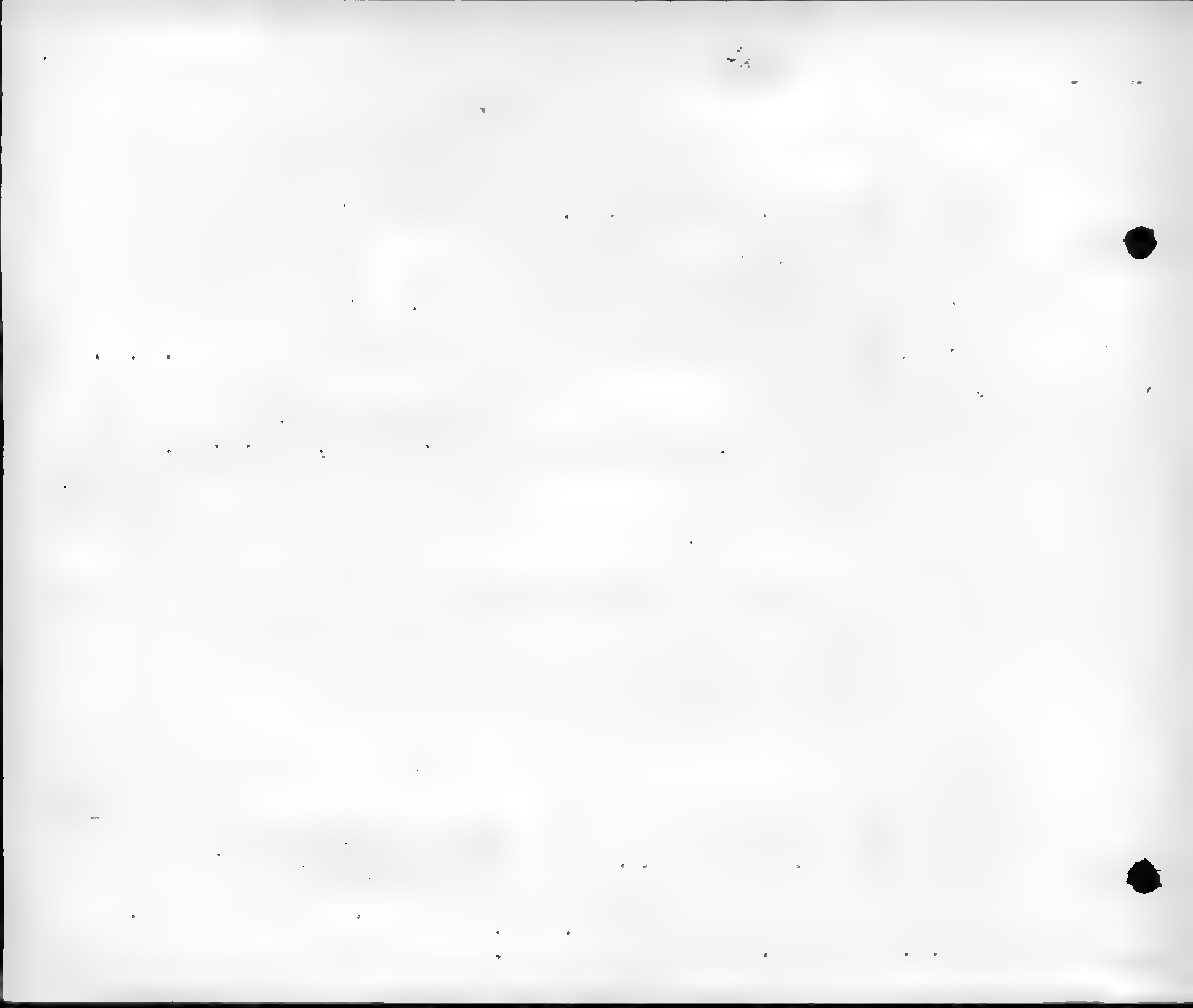
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>117 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admiss on) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>751</b> d. STREET ADDRESS <b>210 South President Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha Eller McCardell</b>				4. DATE OF DEATH Month Day Year <b>March 7 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 25, 1912</b>	
9. AGE (In years last birthday) <b>47 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Millard Eller</b>				14. MOTHER'S MAIDEN NAME <b>Atrie Johnson</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock</b> <b>204.3</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Septicemia ?</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>2 Days</b> <b>4 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>November 11, 1959</b> , to <b>March 7, 1960</b> , that I last saw the deceased alive on <b>March 7, 1960</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-7-60</b>							
ACTUAL SIGNATURE <b>Arthur R. Rothman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>ARTHUR R. ROTHMAN, M.D.</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>removal</b>				22b. DATE THEREOF <b>3/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Conestoga Mem. Park Cem. Lancaster, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

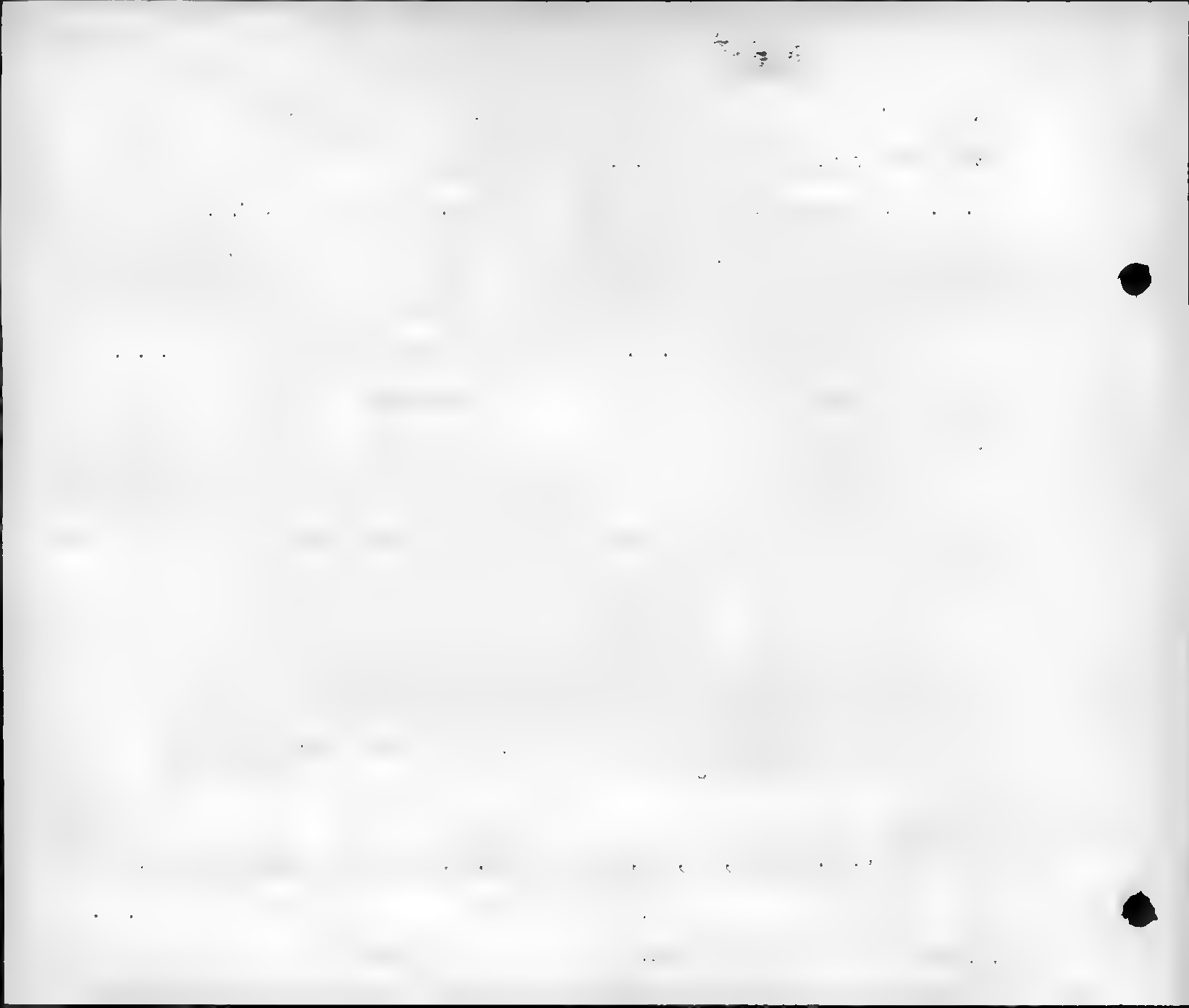


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 3602 CERTIFICATE OF DEATH

03523

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>101 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>647 So. Carolina Ave., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Joseph MC CORMICK</b>				4. DATE OF DEATH Month Day Year <b>March 26 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-85</b>	
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas MC CORMICK</b>				14. MOTHER'S MAIDEN NAME <b>Mary DONAHUE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - bilateral</b> DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatous Chest + Abdomen</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>18 months</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>this hospital</del> attended the deceased from <b>Dec. 16</b> , 19 <b>59</b> , to <b>March 26</b> , 19 <b>60</b> , that (1) <del>was</del> last saw the deceased alive on <b>March 26</b> , 19 <b>60</b> , and that death occurred at <b>2</b> A.M., from the causes and on the date stated above							
22a. SIGNATURE <b>J. E. Hansen</b> 22c. PHYSICIAN'S NAME (Type) <b>J. E. HANSEN, LT, MC, USN</b>				22b. DATE SIGNED <b>3-26-60</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-30-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. T. Ryan Funeral Home, Inc</b> <b>J. T. Ryan Funeral Home, 317 Penn. Ave NW, Wash, DC</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 30 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	



3479

## CERTIFICATE OF DEATH

Reg. Dist. No.

03524

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>31 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hazel</i> First <i>Valema</i> Middle <i>McCreedy</i> Last		4. DATE OF DEATH Month <i>3</i> Day <i>21</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-5-93</i>
9. AGE (In years last birthday) <i>66</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Iowa</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Halver Knutson</i>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Husband + old Records - W.S. + Hosp.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition, weakness, MULTIPLE</i> <i>203x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Nephropathy + renal insufficiency</i> DUE TO <i>MULTIPLE Myeloma</i> (c) <i>23 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>17 months</i> <i>?</i> <i>23 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <i>19</i> Day <i>19</i> Year <i>19</i> Hour <i>a. m.</i> <i>p. m.</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> , 19... to <i>March 21, 1960</i> that I last saw the deceased alive on <i>March 21, 1960</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas H. Wolohin</i>		DATE SIGNED <i>March 21, 1960</i>	
PHYSICIAN'S NAME (Type) <i>Chas H. Wolohin</i>		ADDRESS (Street, city or town, state) <i>2600 Carroll Ave T.P.</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 23, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i> ADDRESS <i>254 Carroll St W.D.</i>		24a. REC'D BY REGISTRAR <i>Mar 23 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

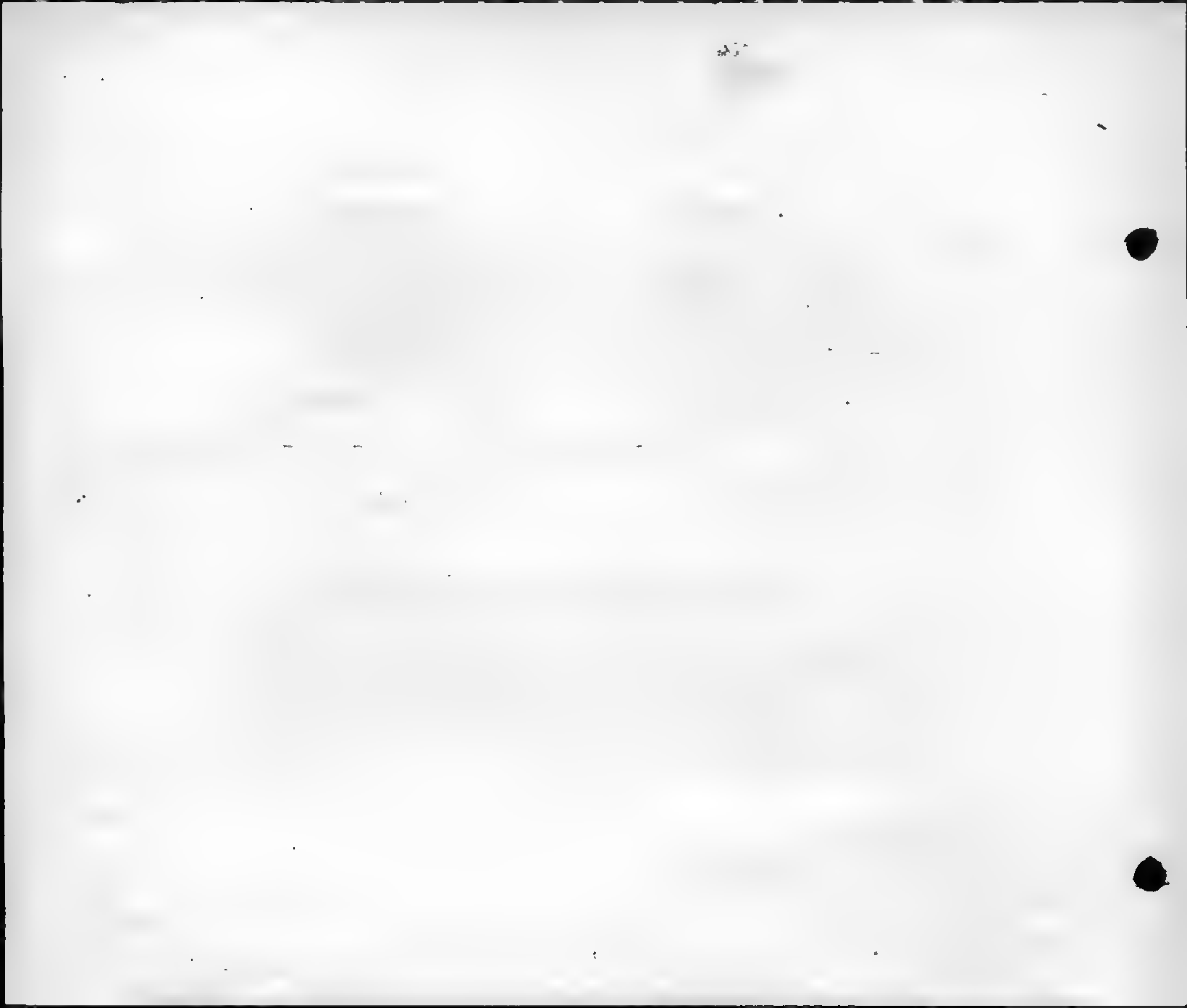
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3603  
CERTIFICATE OF DEATH

03525

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6540 Bradley Boulevard</b>		d STREET ADDRESS <b>6540 Bradley Boulevard</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>P</b> Last <b>McIntyre</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 60</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/21/83</b>
9. AGE (In years lost birthday) yrs <b>77</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer -retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11 BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Samuel T. McIntyre</b>		14. MOTHER'S MAIDEN NAME <b>Martha Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>517-38-2931</b>	
17 INFORMANT <b>Leala McIntyre-wife-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebrovascular - Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 years</b> <b>1 yr.</b> <b>3 1/2 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>3/27</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>3/26</b> , 19 <b>60</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a SIGNATURE <b>Maurice Menash MD</b>		22b DATE SIGNED <b>3/28/60</b>	
22c PHYSICIAN'S NAME (Type) <b>MAURICE MENASH MD</b>		22d ADDRESS <b>1732 - Eye St N.W. - Wash. D.C.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b DATE THEREOF <b>3/28/60</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		25c DATE <b>MAR 30 '60</b>	





3604

## CERTIFICATE OF DEATH

Reg. Dist. No.

03526

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Auguste C. McPherson</b>				4. DATE OF DEATH Month Day Year <b>March 27 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1877</b>	9. AGE (In years lost birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Ruben Clark</b>				14. MOTHER'S MAIDEN NAME <b>F. Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>Son) George Wenkenbach - same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Posterior, Septal, Left Ventricle</b> 420.1 DUE TO <b>Thromboses - Posterior and Anterior descending Coronary Arteries</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Coronary Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> 1953 to <b>March 27</b> 1960 that I last saw the deceased alive on <b>March 27</b> 1960 and that death occurred at <b>10:40</b> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stewart Clapp</b>				ADDRESS (Street, city or town, state) <b>3921 Ingomar St. Wash 15 D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>				DATE SIGNED <b>3-27-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3605

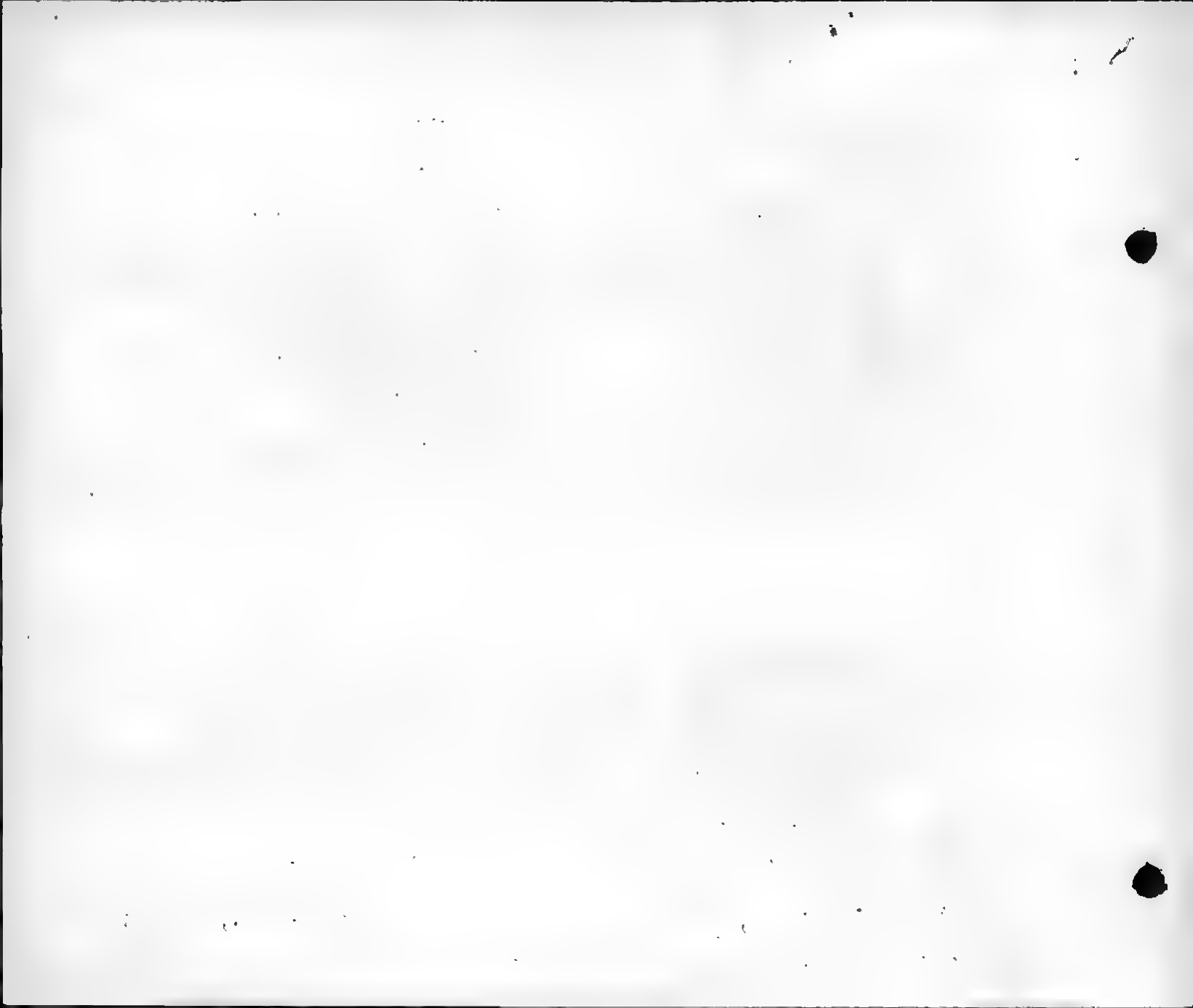
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>6</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>14 days</b>		d. STREET ADDRESS <b>7059 Wyndale St., N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Royal</b> Middle <b>Seeley</b> Last <b>McRae</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/17</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>18</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY (11. BIRTHPLACE (State or foreign country) <b>Los Angeles, Calif.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy C. Seeley</b>		14. MOTHER'S MAIDEN NAME <b>Mahala Calvin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b> INFORMANT <b>Husband (Robert)</b> Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Adeno-Carcinoma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Left Breast Adeno-Carcinoma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>? yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>54</b> , to <b>March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 17</b> , 19 <b>60</b> , and that death occurred at <b>7:15pm</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Leo I Donovan M.D.</b>		ADDRESS (Street, city or town, state) <b>8016 GEORGETOWN RD 3/18/60</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>LEO I DONOVAN MD</b>		<b>BETHESDA 14 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Fort Gaines, Georgia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Charles Sims</b> ADDRESS <b>1754 Pennsylvania Ave</b>		24a. REC'D BY REGISTRAR <b>MAR 21 '60</b> 24b. REGISTRAR'S SIGNATURE <b>William S. Knecht</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3499

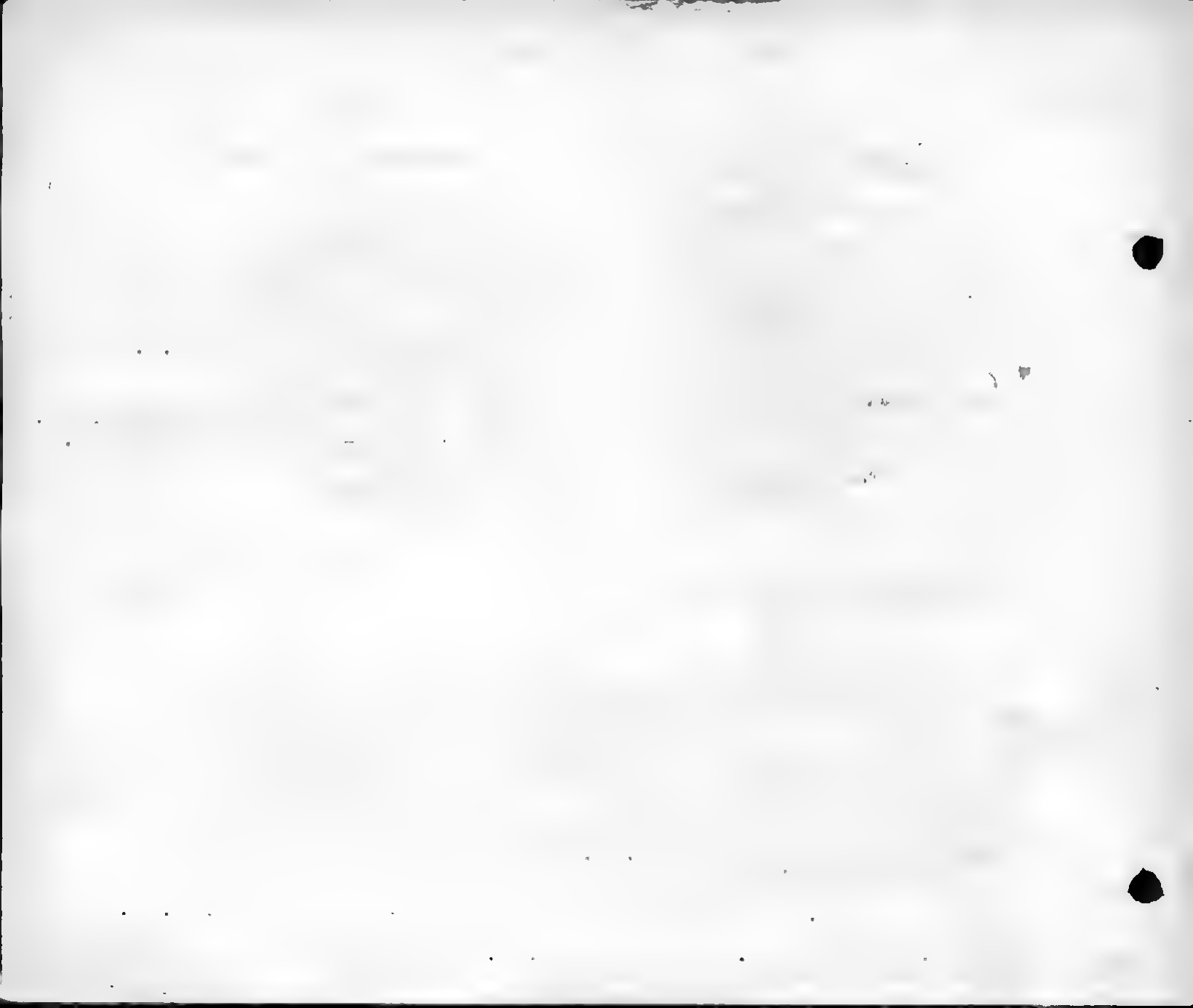
## CERTIFICATE OF DEATH

03528

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Montgomery</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>4621 DeRussey Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>M.</b> Last <b>McWhorter</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.	11. IF UNDER 24 HRS Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Newton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Arnett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Louise Gathgens-4621 DeRussey Pkway.</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute heart failure</b> <b>491X</b> DUE TO (b) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>Mar. 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Mar. 20</b> , 19 <b>60</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas F. McMahon</b> M.D.		ADDRESS (Street, city or town, state) <b>3000 Conn. Ave. Wash. D.C. 20008</b>	
PHYSICIAN'S NAME (Type) <b>Thomas F. McMahon, M. D.</b>		DATE SIGNED <b>Mar 20 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>		24a. REC'D BY REGISTRAR <b>MAR 22 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

It is 3-15-68 270

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 3606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03529

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Washington, District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		d. STREET ADDRESS <b>3601 Livingston St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Herbert John MENERATTI</b>		4. DATE OF DEATH <b>March 3 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy (Retired)</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>August MENERATTI</b>		14. MOTHER'S MAIDEN NAME <b>Nellie MAES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW-I&amp;II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Official Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary sclerosis, moderate</b> <b>420.1</b> DUE TO (b) <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulmonary edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschert</b>		M.D.	
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL		22b. DATE THEREOF <b>3-7-68</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR <b>Deal Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
ADDRESS <b>4812 Georgia Ave. N.W. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MAR 9 '60

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3607

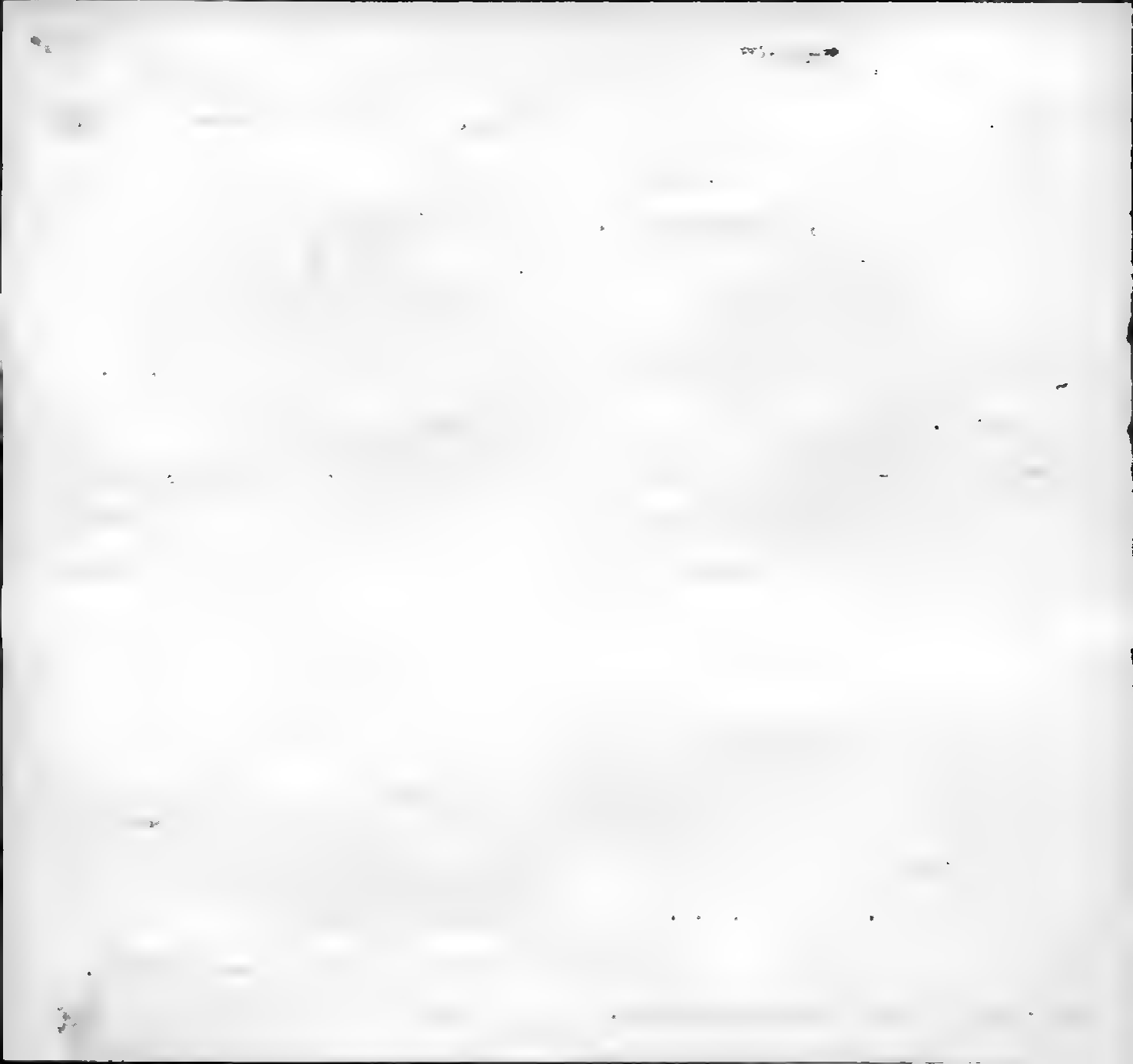
## CERTIFICATE OF DEATH

Reg. Dist. No.

03530

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>75 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>2201 Guilford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Moore</b> Last <b>Mister</b>			4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1910</b>		9. AGE (In years last birthday) yrs <b>49</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William F. Mister</b>		
14. MOTHER'S MAIDEN NAME <b>Ida Moore</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> If yes, give year or dates of service <b>1928-1929</b>		
16. SOCIAL SECURITY NO. <b>Unascertainable</b>			INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Brainstem neoplasm</b> DUE TO (c) <b>10 months</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1:45 P.M.</b>	
20f. (City or town) <b>Bethesda</b>		(County) <b>Prince Georges</b>		(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>January 13, 1960</b> , to <b>March 28, 1960</b> , that I last saw the deceased alive on <b>March 28, 1960</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b>					
ACTUAL SIGNATURE <b>Paul H. Altrocchi, M.D.</b>		M.D. <b>The Clinical Center</b>		DATE SIGNED <b>3/28/60</b>	
PHYSICIAN'S NAME (Type) <b>Paul H. Altrocchi, M.D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMAT., OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belle Haven Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Belle Haven, Virginia.</b>		(State) <b>Virginia</b>		24a. REC'D BY REGISTRAR <b>APR 1 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Henshaw</b>	

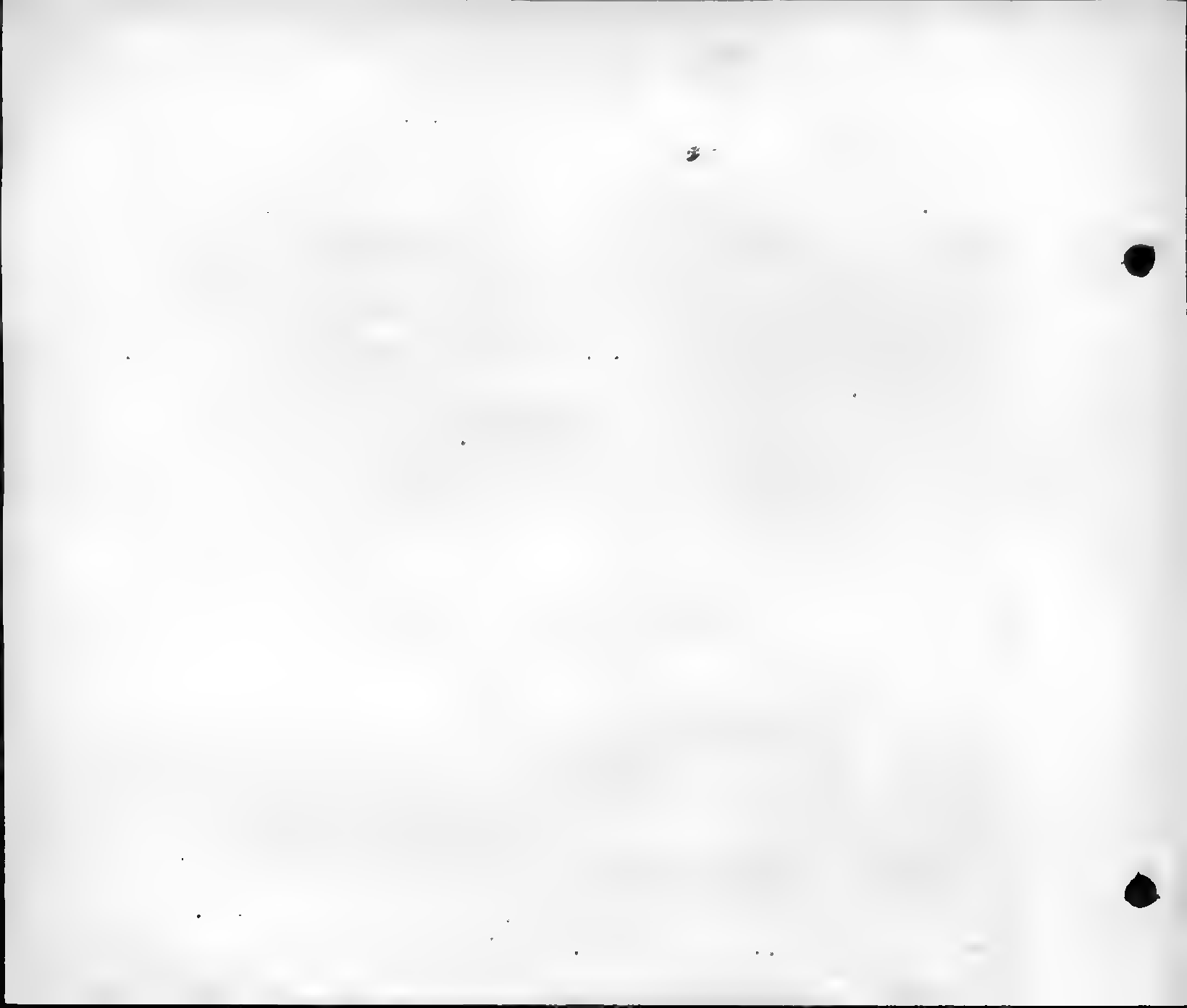
MEDICAL CERTIFICATION



1  
3608  
MONTGOMERY  
MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03531

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA NURSING HOME</b>				d. STREET ADDRESS <b>3164 O Street, N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>MOLYNEAUX</b> Last <b>MOLYNEAUX</b>				4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/24/1872</b>	
9. AGE (In years last birthday) <b>87</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Naval Gun Factory, U.S. Govt</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Battle Creek, Mich</b>			
13. FATHER'S NAME <b>Robert Wm. Molyneaux</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes Spanish-Amer</b>				16. SOCIAL SECURITY NO		17. INFORMANT <b>John Wm. Holyneaux</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary-Sclerotic Heart Disease</b> DUE TO (c) <b>Thrombotic Coronary-Sclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/4/1960</b> to <b>3/13/1960</b> that (I) (we) last saw the deceased alive on <b>3/11/1960</b> and that death occurred <b>1/4/1960</b> from the causes and on the date stated above							
22a. SIGNATURE <b>E. Stuart Lydane</b>				22b. DATE SIGNED <b>3/13/60</b>		22c. PHYSICIAN'S NAME (Type) <b>E. STUART LYDANE</b>	
22d. ADDRESS <b>3066 - Gump St. N.W. Washington D.C.</b>				22e. ADDRESS <b>3066 - Gump St. N.W. Washington D.C.</b>			
23a. BURIAL, CREMATION, REMAINS (Specify)				23b. DATE THEREOF <b>3/17/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery Arlington, Va.</b>	
23d. LOCATION (City, town, or county) (State)				23e. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>Arthur J. Hines</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
3609 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03532														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if not full time; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown R-1</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown - R-1</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brink Road</u>					d. STREET ADDRESS <u>Brink Road</u>									
3. NAME OF DECEASED (Type or print) First <u>Lon</u> Middle <u>moore</u> Last <u>moore</u>					4. DATE OF DEATH Month <u>Mar</u> Day <u>5</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1909</u>		9. AGE (In years last birthday) <u>50</u> yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>Thomas Moore</u>					14. MOTHER'S MAIDEN NAME <u>Kate Anderson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Ada Moore (wife)</u> <u>Jim</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>3-5-60</u>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) _____									
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3-9-60</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Germantown Baptist</u>				
					22d. LOCATION (City, town, or county) <u>Germantown</u>					(State) <u>Md</u>				
23. FUNERAL DIRECTOR <u>Ernest C. Garton</u>					ADDRESS <u>Gaithersburg, Md</u>					24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>									



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G2-1, 3-16-60, 1b

3610

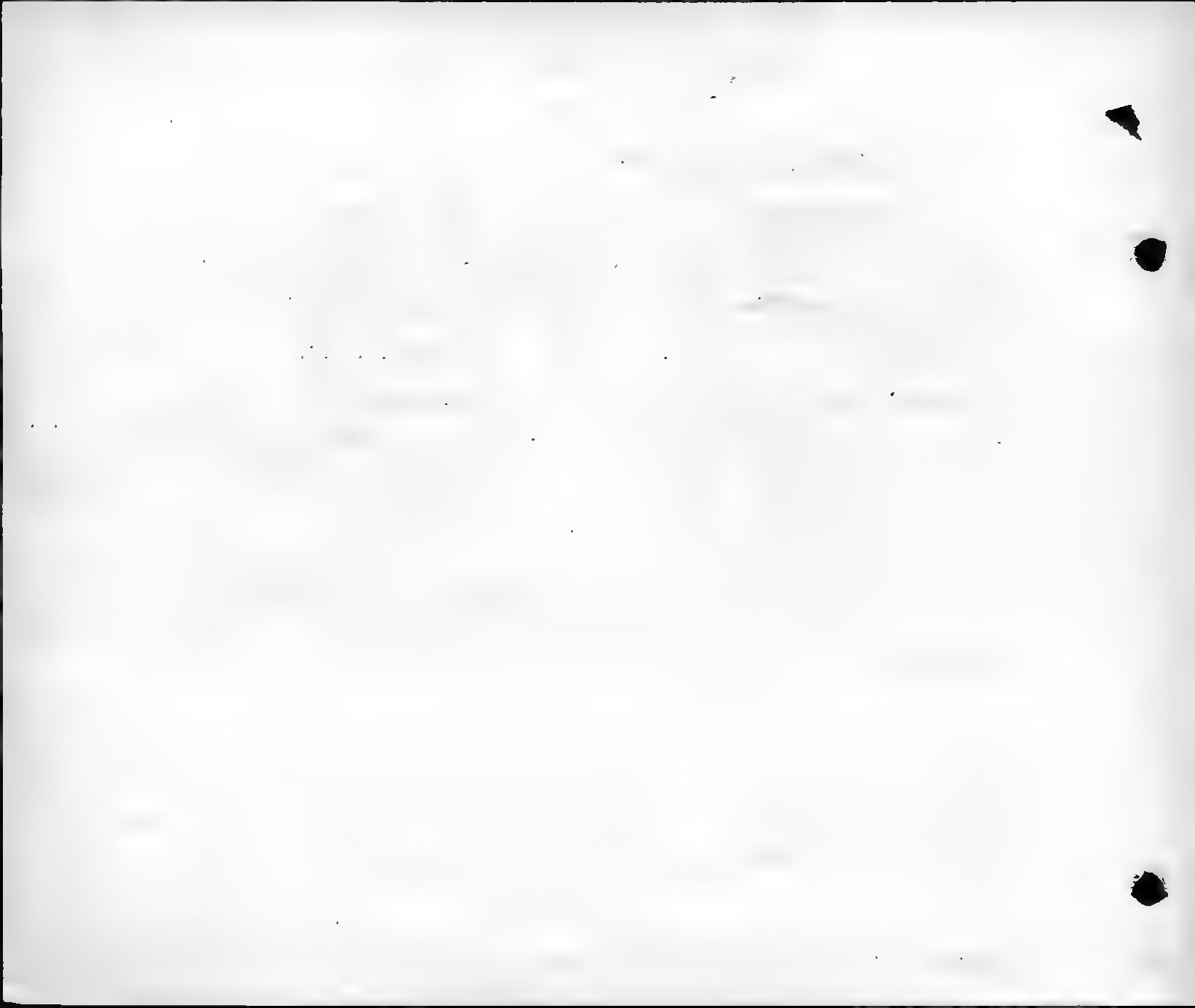
## CERTIFICATE OF DEATH

Reg. Dist. No.

03533

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>WASHINGTON</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA (RURAL)</b>				c. LENGTH OF STAY IN 1b <b>1 MONTH</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Radford</b> Middle <b>(n)</b> Last <b>MOSES</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucassian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-14-89</b>	
9. AGE (In years last birthday) <b>70 1/2</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>10</b> Hours <b>10</b> Min.		11. IF UNDER 24 HRS. Months <b>11</b> Days <b>10</b> Hours <b>10</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>			
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William H. MOSES</b>				14. MOTHER'S MAIDEN NAME <b>Estelle Maloy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>577 40 9608</b>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>WWI &amp; WWII</b>				18. INFORMANT <b>Mrs. Emma May MOSES, 3839 Livingston ST N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Ureteral obstruction</b> DUE TO (c) <b>Adenocarcinoma of Prostate</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 days</b> <b>5 Plus yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2 Feb</b> , 19 <b>60</b> , to <b>12 Apr</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11 Mar</b> , 19 <b>60</b> , and that death occurred at <b>0824 AM</b> , from the causes and on the date stated above.							
INITIAL SIGNATURE <b>d/s. Irons</b>				ADDRESS (Street, city or town, state) <b>Bethesda Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>H. S. IRONS, LT, MC, USN</b>				DATE SIGNED <b>3/12/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-16-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Birch</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 15 '60</b>			
ADDRESS <b>3034 M Street, N.W., Wash. D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3480

## CERTIFICATE OF DEATH

Reg. Dist. No.

03534

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>1 yr 10 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAKHAYN CONValescent HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4900 Hillbrook Lane</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH HERTZLER MURRAY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1, 1861</u>
9. AGE (In years last birthday) <u>98</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>TENN'A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John HERTZLER</u>		14. MOTHER'S MAIDEN NAME <u>FANNY FISHMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO _____	
17. INFORMANT <u>ALBERT F. MURRAY (SON)</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>794x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal Virus infection</u> DUE TO (c) <u>Cardiatic Illness</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 17, 1955</u> to <u>March 1, 1960</u> , that I last saw the deceased alive on <u>March 1, 1960</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u>3-1-60</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>3-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>SUTLAND, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. ...</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '60</u>	
ADDRESS <u>1756 12th St. N.W.</u> <u>Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



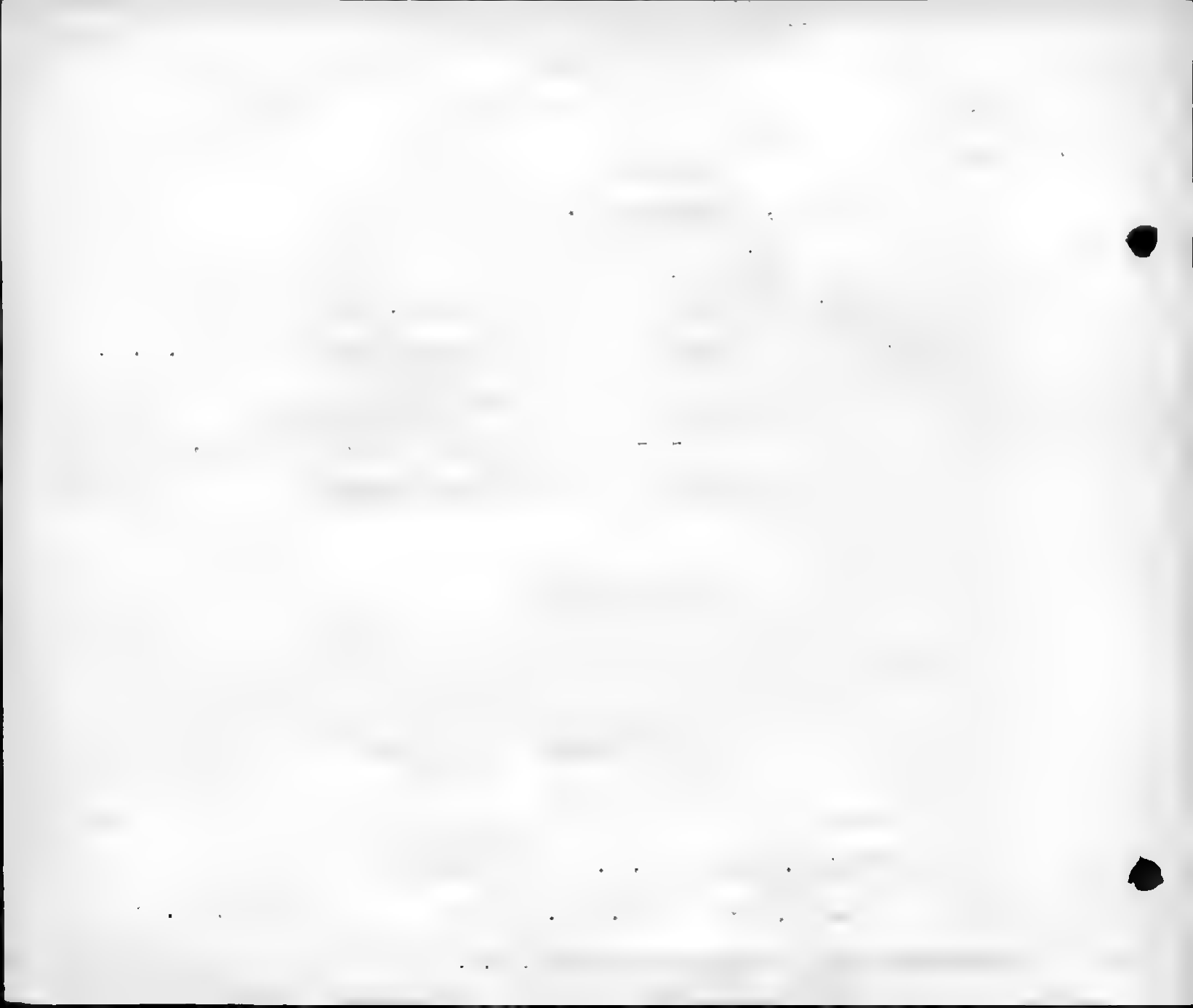
3611

## CERTIFICATE OF DEATH

Reg. Dist. No.

03535

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>76 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>David</b> Last <b>Neff</b>			4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1918</b>		9. AGE (In years lost birthday) <b>42</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>	11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Harry Neff</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Blum</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-4139</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>190.9</b> DUE TO <b>Widely metastatic malignant melanoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 4</b> , 19 <b>60</b> , to <b>March 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 20</b> , 19 <b>60</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/21/60</b> ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 22, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>	
				22d. LOCATION (City, town, or county) (State) <b>Falls Church, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herman Goldberg - Goldberg 4217 9th St. N.W.</b>			24a. REC'D BY REGISTRAR <b>MAR 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

March 4/1960

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3446

03536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>C 121, Norwood Road</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas Francis Nelson, Jr.</u>		4. DATE OF DEATH <u>March 16 19 60</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 11/60</u>	9. AGE (In years last birthday) <u>5</u>	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Thomas Francis Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Johnson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records, Olney, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, ... D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rooky Hill, Clarksville, Md.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Surod</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanes</u>			
		DATE <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03537

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery, Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u>		First <u>Newcomb</u> Middle <u>Newcomb</u> Last <u>Newcomb</u>		4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/60</u>	
9. AGE (In years last birthday) <u>14</u> yrs		IF UNDER 1 YEAR Months <u>14</u> Days <u>16</u>		IF UNDER 24 HRS Hours <u>14</u> Min <u>16</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Edward Newcomb</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gayle Renfro</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <u>James Edward Newcomb 33 West Notley Rd., S.S.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14 Hr. 16</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5:56 March 12 1960</u> to <u>March 13 1960</u> , that (I) (we) last saw the deceased alive on <u>March 13 1960</u> , and that death occurred at <u>8:26 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Winston E. Cochran M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 29</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>927 Pershing Drive, S.S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>March 15, 1960</u>		<u>Washington Sanitarium &amp; Hospital, Takoma Park Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. &amp; Hospital</u>				25a. REC'D BY REGISTRAR <u>MAR 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Mar 4/60





3612

## CERTIFICATE OF DEATH

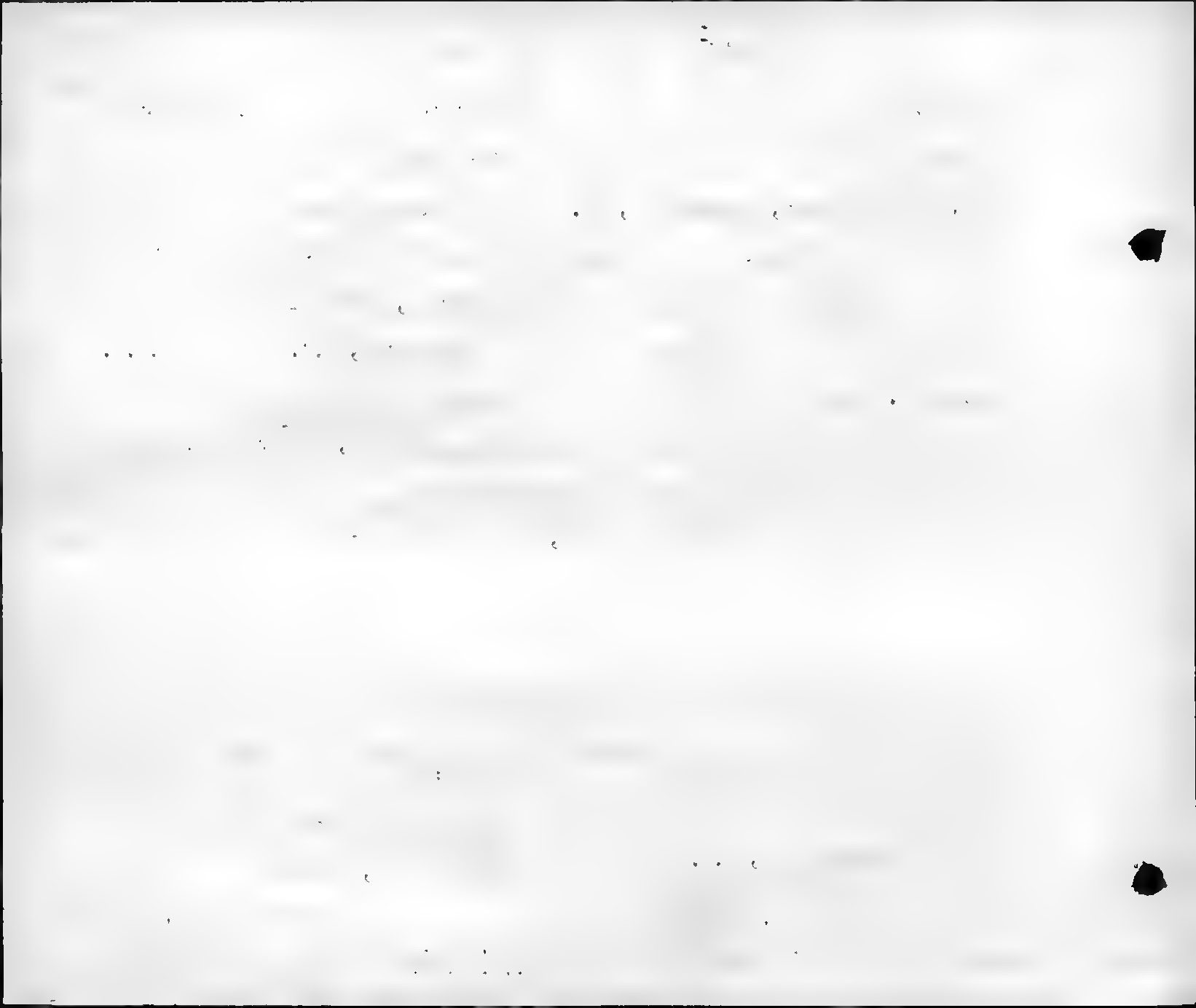
Reg. Dist. No.

03538

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>1023 Potomac Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Frederick</b> Last <b>Nissen</b>				4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 24, 1958</b>		9. AGE (In years lost birthday) yrs. <b>1</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Spencer T. Nissen</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post exploratory thoracotomy</b> DUE TO <b>Cyanotic congenital heart disease (transposition, single ventricle)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>23 hours</b> <b>14 months</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 6</b> , 19 <b>60</b> , to <b>March 17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 17</b> , 19 <b>60</b> , and that death occurred at <b>9:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/17/60</b> ACTUAL SIGNATURE <b>Roland Folse</b> PHYSICIAN'S NAME (Type) <b>Roland Folse, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Comfort</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax County, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Barclay Mount</b>				24. REC'D BY REGISTRAR <b>Cunningham Funeral Home, Inc.</b> <b>Cameron &amp; Alfred Sts., Alex.</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**3613**

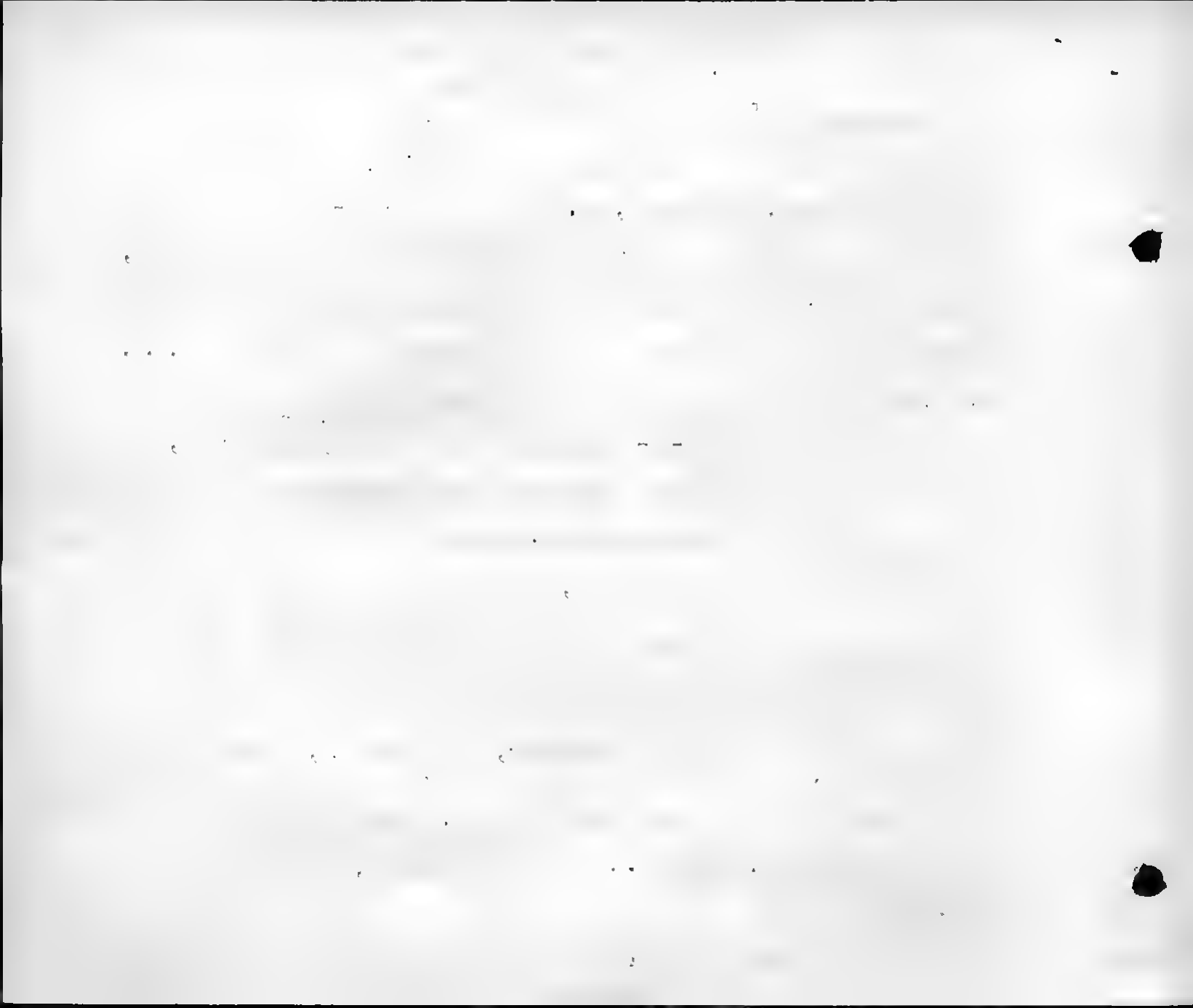
**CERTIFICATE OF DEATH**

03539

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Madison</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>115 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Nat</b> Middle <b>Smith</b> Last <b>Norfleet</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24, 1937</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nat Norfleet</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>264-48-8864</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, left frontal lobe</b> 204.3 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Acute Myelogenous leukemia</b> DUE TO (c) <b>Aspergillosis, disseminated</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 27, 1959</b> to <b>March 21, 1960</b> , that I last saw the deceased alive on <b>March 21, 1960</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b> M.D.		DATE SIGNED <b>3/21/60</b>	
PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans</b>	22b. DATE THEREOF <b>3/22/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Madison, Florida</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 28 60</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



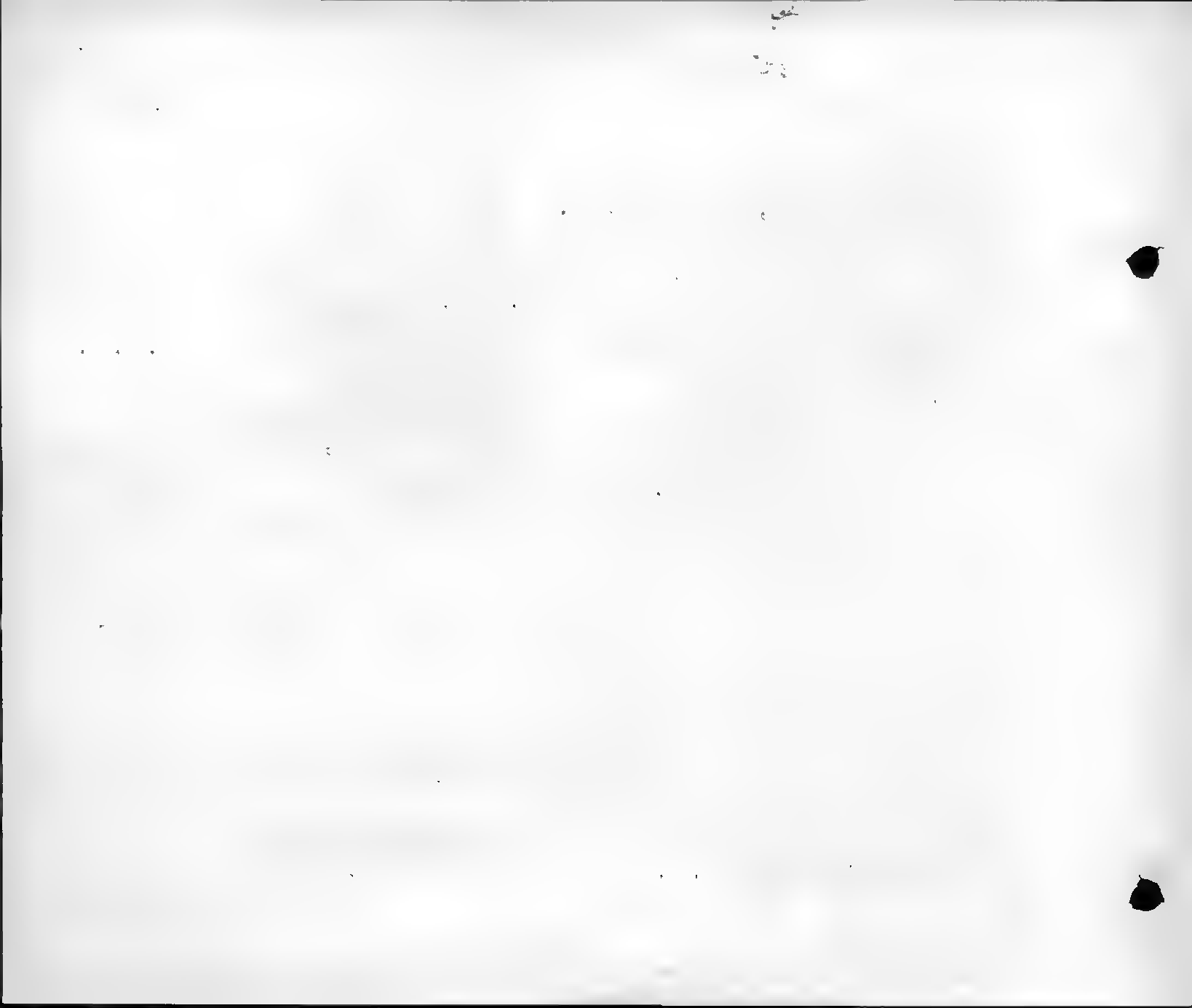
## 3614 CERTIFICATE OF DEATH

Reg. Dist. No. 03540

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairway Hills</b>			
f. STREET ADDRESS <b>6208 Crathie Lane</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Eileen</b> Last <b>Nunley</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1920</b>		9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>	IF UNDER 24 HRS Hours <b>7</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>News Reporter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Journalism</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Appleton</b>				14. MOTHER'S MAIDEN NAME <b>Eileen Donahue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage into lungs</b> DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of breast</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 6</b> , 19 <b>60</b> , to <b>March 7</b> , 19 <b>60</b> that I last saw the deceased alive on <b>March 7</b> , 19 <b>60</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/8/60</b> ACTUAL SIGNATURE <b>Howard Schwartz</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>HOWARD SCHWARTZ, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL (CREMATION REMOVAL) (Specify)		22b. DATE THEREOF <b>3/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lee's</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Lee</b> ADDRESS <b>300 - 4 St NE</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE RETURNED TO THE STATE BOARD OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

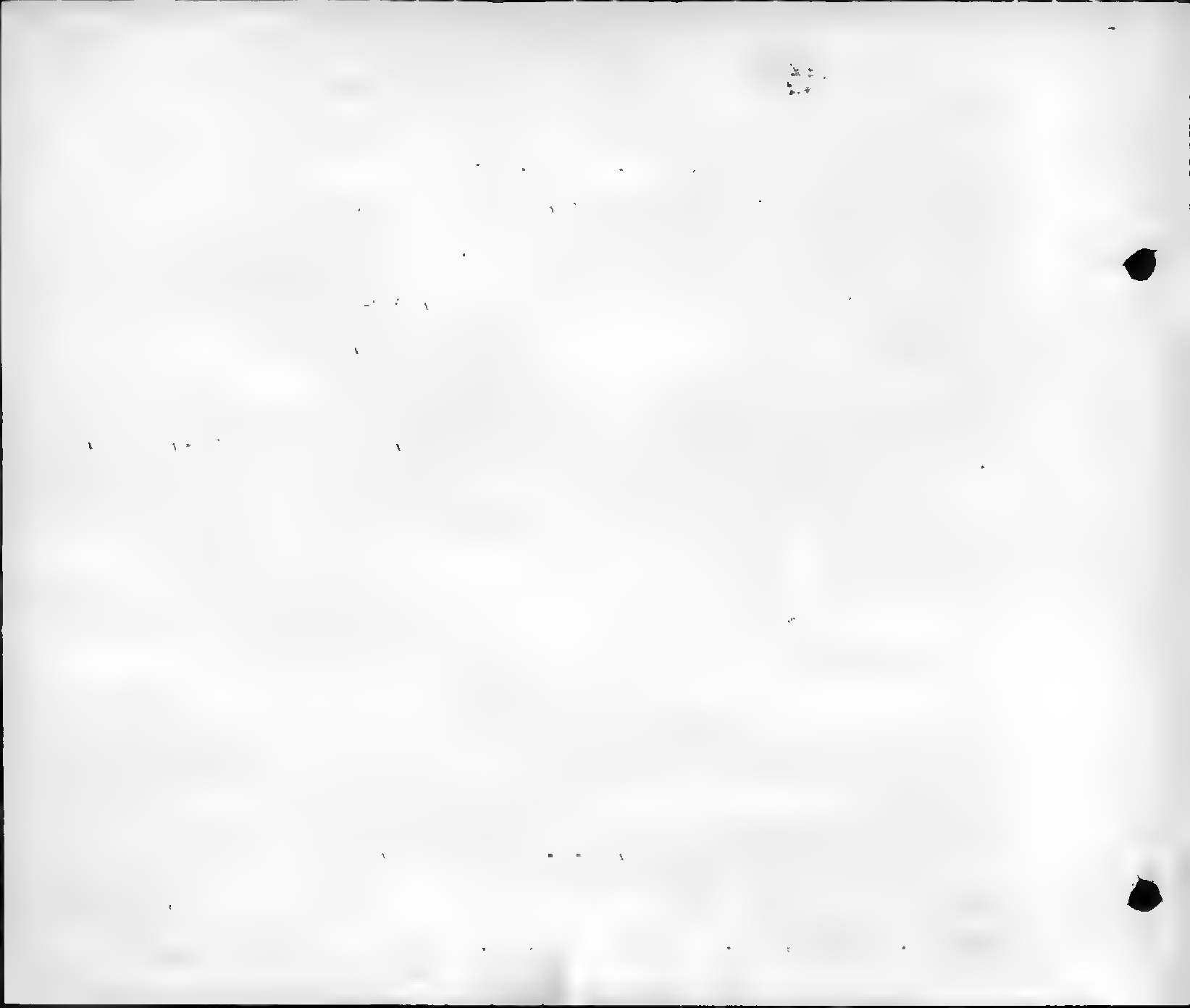
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3615

CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 5 hrs. 20 min.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Kathleen Mary Odum				4. DATE OF DEATH March 6 1960															
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1947		9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolgirl				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bernard Paul Odum								14. MOTHER'S MAIDEN NAME Doris Mayhew											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO none				17. INFORMANT Odum Doris Mayhew, Hillcrest Ave., Olney, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 477X DUE TO Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b): (c): PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Cerebral Palsy												INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 6 1960 to March 6 1960, that (I) (we) last saw the deceased alive on March 6 1960, and that death occurred at 6:00 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Richard A. Yates, M.D.								22b. DATE SIGNED 3/6/60											
22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.								22d. ADDRESS Olney, Maryland											
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/8/60				23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND							
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.								ADDRESS SILVER SPRING, MD.				25a. REC'D BY REGISTRAR DATE MAR 9 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



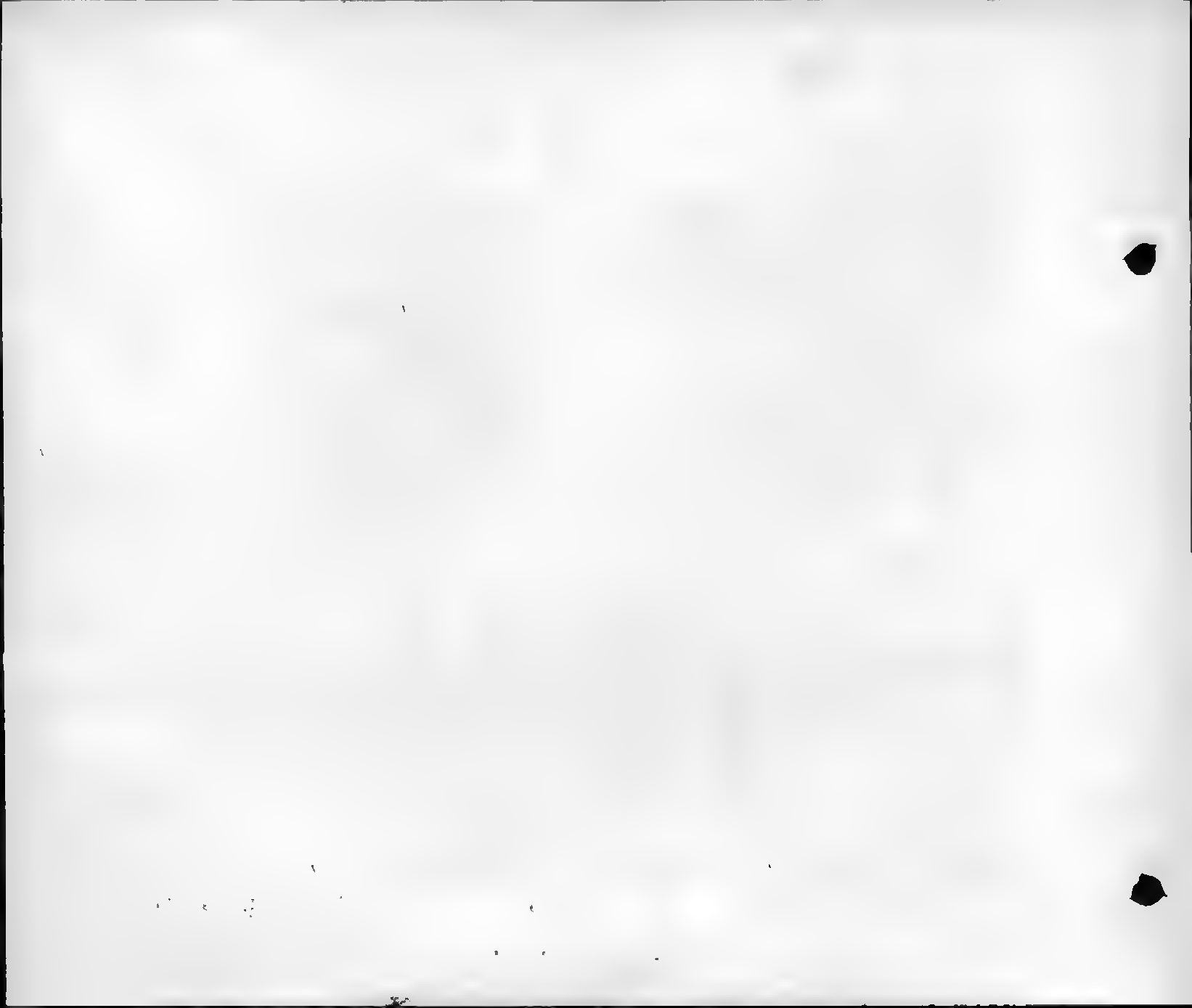


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
3616  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
03542  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 hr 20 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Box 62</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Ernest Offord</u>		4. DATE OF DEATH Month Day Year <u>March 13 1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 7, 1920</u>
9. AGE (In years last birthday) <u>39</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Tolbert Offord</u>		14. MOTHER'S MAIDEN NAME <u>Ada Virginia Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>Gladys Virginia Offord</u>	
17. INFORMANT <u>Sandy Spring,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>49 IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty metamorphosis of liver</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MED CAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (This hospital) attended the deceased from <u>10/25/60</u> to <u>3/13/60</u> , that (I) (we) last saw the deceased alive on <u>3/12/60</u> , and that death occurred at <u>6:40a</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/13/60</u>	
22c. PHYSICIAN'S NAME <u>C. H. Ligon M. D.</u>		22d. ADDRESS <u>Sandy Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

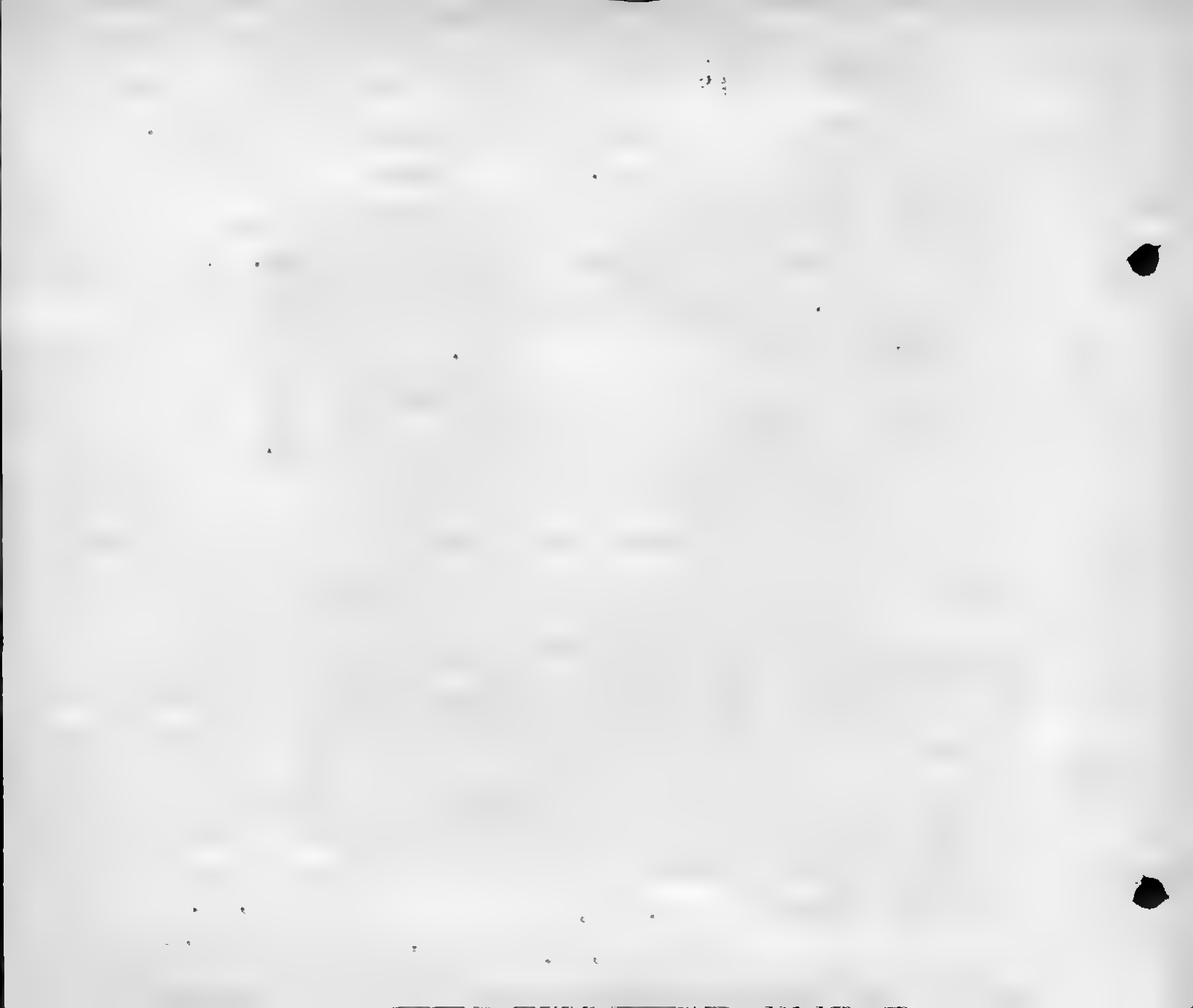
3617 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>RFD #1 Derwood</b>		c. LENGTH OF STAY IN 1b <b>3 wks.</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montg.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Comas</b>		d. STREET ADDRESS <b>Comas</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nettie Lumar Onley</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>30,</b> Year <b>1960</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/1895</b>		9. AGE (in years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b>		11. IF UNDER 24 HRS. Hours <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mt.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Hayes</b>		14. MOTHER'S MAIDEN NAME <b>Edmonia Fields</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eleanor Ambush, Comas Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Disease</b> 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arterio sclerosis</b> DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/31/60</b>		ACTUAL SIGNATURE <i>Frank J. Broschart</i>		EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion,</b>		22d. LOCATION (City, town, or country) <b>Barnesville, Md.</b>		23. FUNERAL DIRECTOR <b>Robert L. Lumsden</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 4 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Lumsden</i>		24c. (City or town) (County) (State)		24d. (City or town) (County) (State)			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

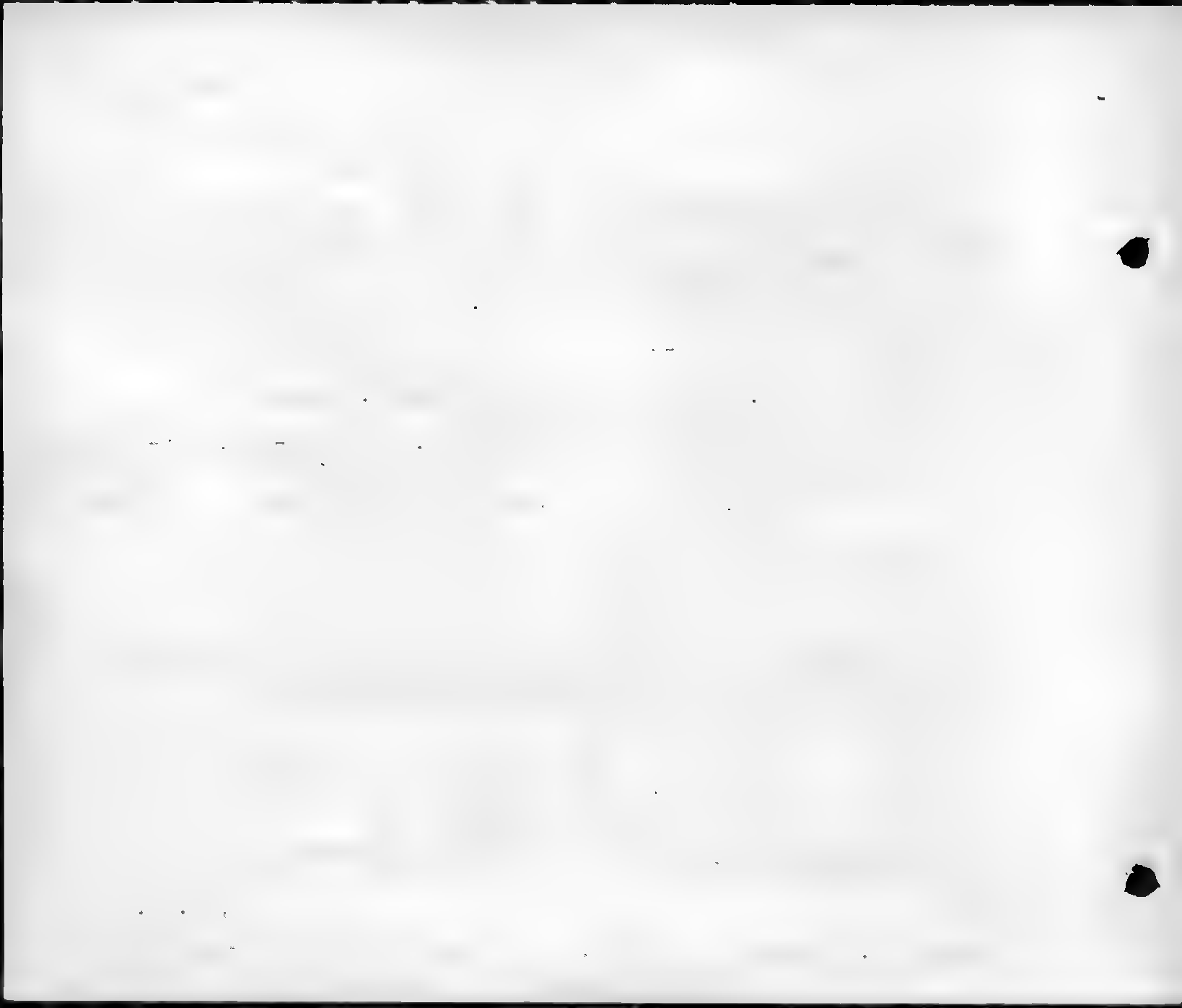
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3511

CERTIFICATE OF DEATH

03544

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3615 Calvend Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANCES</b> First <b>OVINGTON</b> Middle Last		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Johnathan T. Spry</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Taggart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frances S. Ovington-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a m <b>19</b> p m		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 1, 1960</b> , to <b>March 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1960</b> and that death occurred at <b>1025 CONNETTICUT AVE NW, WASH, DC</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas S. Sappington</b>		22b. DATE SIGNED <b>March 5, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS S. SAPPINGTON</b>		22d. ADDRESS <b>1025 CONNETTICUT AVE NW, WASH, DC</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCAT ON (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>MAR 11 '60</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

03545

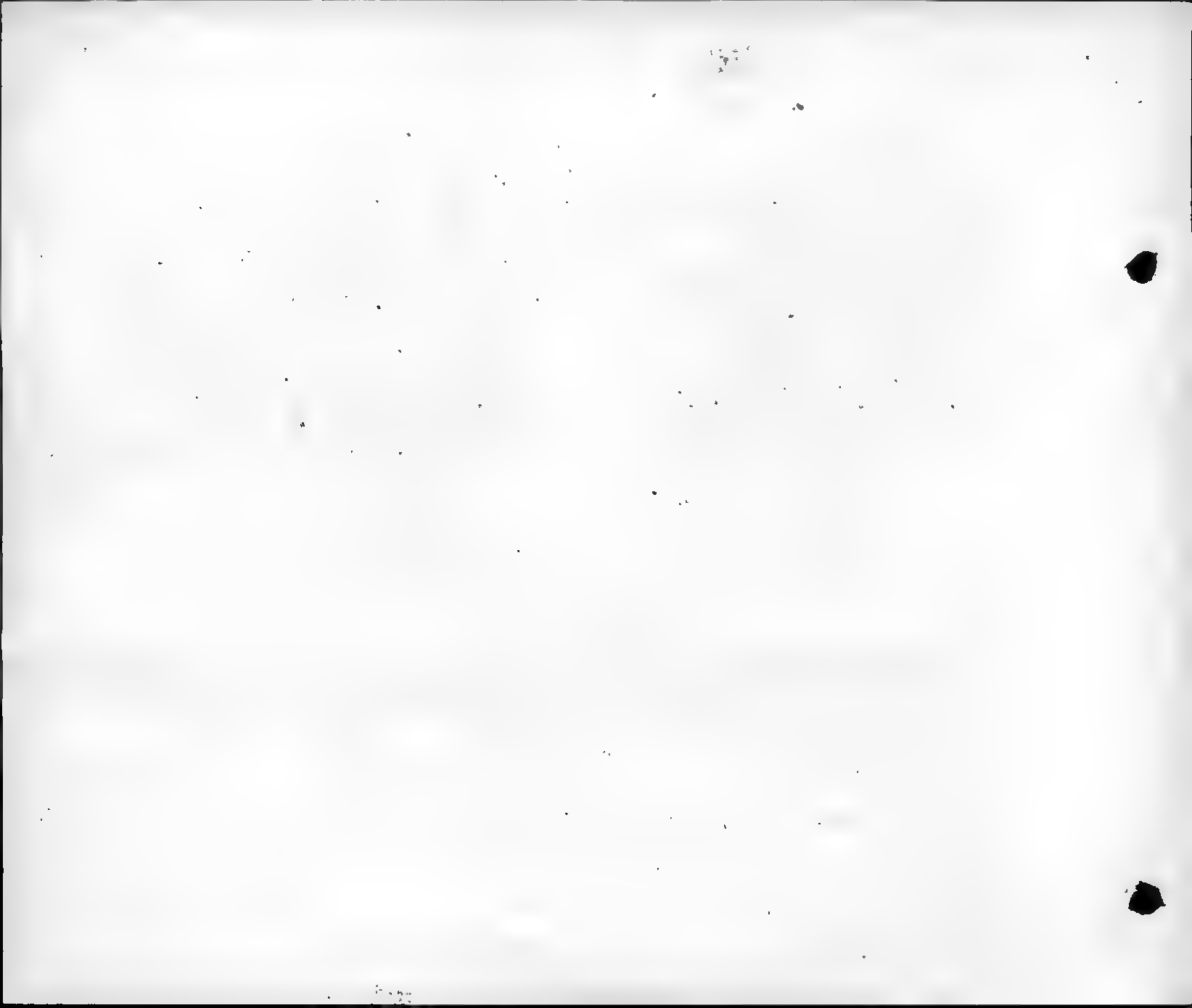
3618

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bay</u> <u>Painter</u>		4. DATE OF DEATH Month Day Year <u>3</u> <u>27</u> <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1960</u>
9. AGE (In years lost birthday) <u>2 days</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>2</u> <u>6</u>	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Douglas F. Painter</u>	
14. MOTHER'S MAIDEN NAME <u>Barbara Williams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		INFORMANT Address <u>Father Douglas F. Painter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pulmonary atelectasis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 25, 1960</u> to <u>Mar. 27, 1960</u> , that I last saw the deceased alive on <u>Mar. 27, 1960</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Harold M. Hobart</u> M.D. <u>5402 Conn. Ave. D.C.</u> <u>3/27/60</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>HAROLD M. HOBART</u> <u>5402 CONN. AVE. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Derwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Derwood, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074-233 XV4





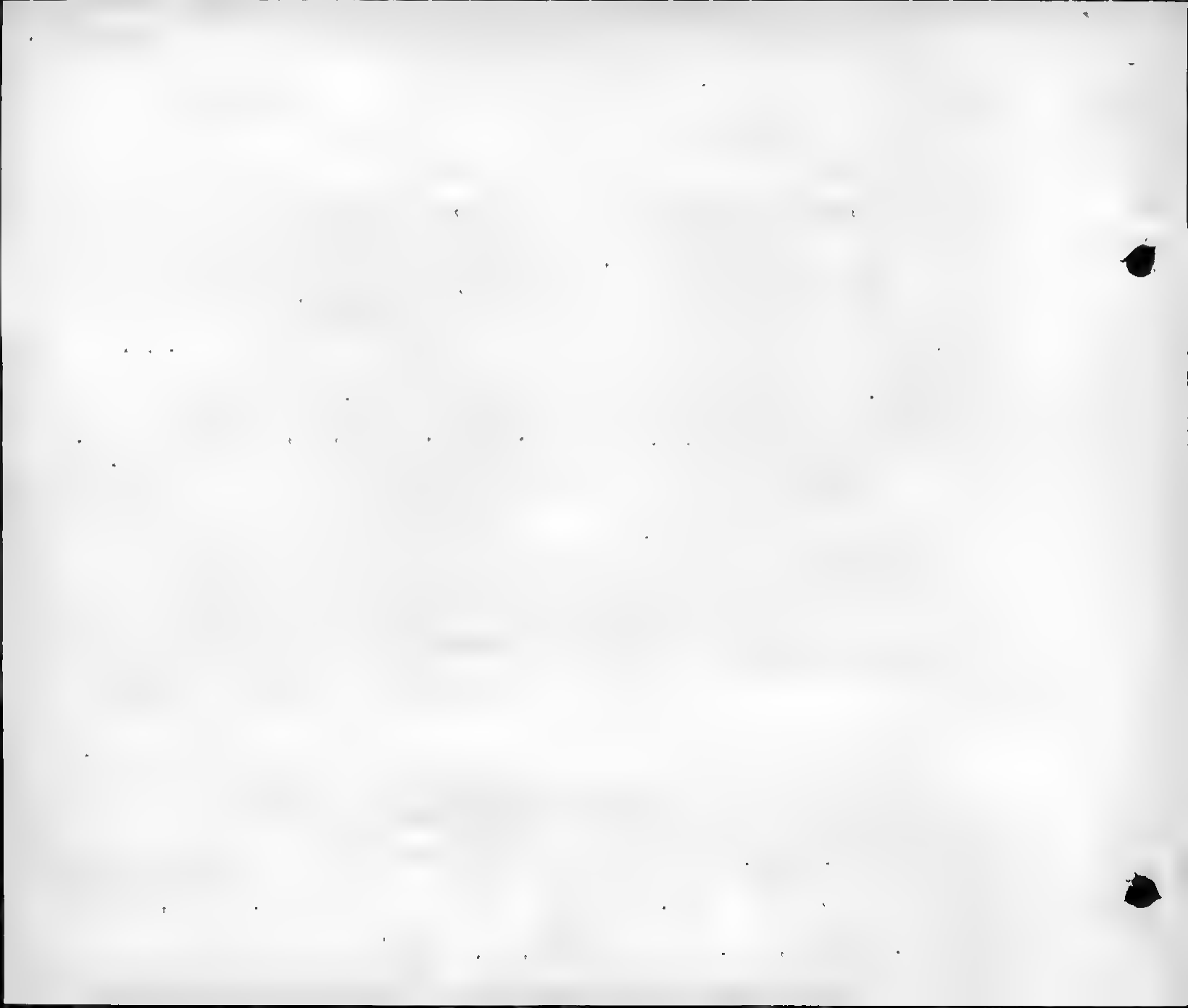
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach to the other papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
3447  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03546

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,202 GRANDVIEW AVENUE				d. STREET ADDRESS 12,202 GRANDVIEW AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE U. PARKER				4. DATE OF DEATH Month Day Year MARCH 12 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/86	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS H. PARKER				14. MOTHER'S MAIDEN NAME MARIA V. JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-18-0536		17. INFORMANT Mrs. Maud S. Parker, 12,202 Grandview Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO 193 X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				accute Pulmonary Edema Cancer of Lung Interval BETWEEN ONSET AND DEATH March 11 - March 12, 1960 John 1957-22-86			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 19 57, to March 12 19 60, that (I) (we) last saw the deceased alive on March 11 1960, and that death occurred at 4 PM, from the causes and on the date stated above.							
22a. SIGNATURE Michael R. Dobridge				22b. ADDRESS 16620 Georgia Ave. Silver Spring, Md.			
22c. PHYSICIAN'S NAME (Type) MICHAEL R. DOBRIDGE				22d. ADDRESS 16620 Georgia Ave. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond W. Basha				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 15 '60	
				25b. REGISTRAR'S SIGNATURE Charles L. Hanna			



3492

## CERTIFICATE OF DEATH

03547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2625 Carroll Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Lanning</u> Last <u>Persons</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Ada Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
INFORMANT <u>E. Jones</u> Address <u>2625 Carroll Hwy Takoma Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> <u>153.0</u> DUE TO (b) <u>Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unk.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22</u> , 19 <u>60</u> to <u>3-4</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>March 3</u> , 19 <u>60</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Regis. B. Parsons Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>504 North St. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons Jr.</u>		DATE SIGNED <u>March 4, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Mar 8, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>254 Carroll St. NW D.C.</u>		22d. LOCATION (City, town, or county) (State) <u>SALEM, SALEM Co. N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR <u>Mar 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3619

## CERTIFICATE OF DEATH

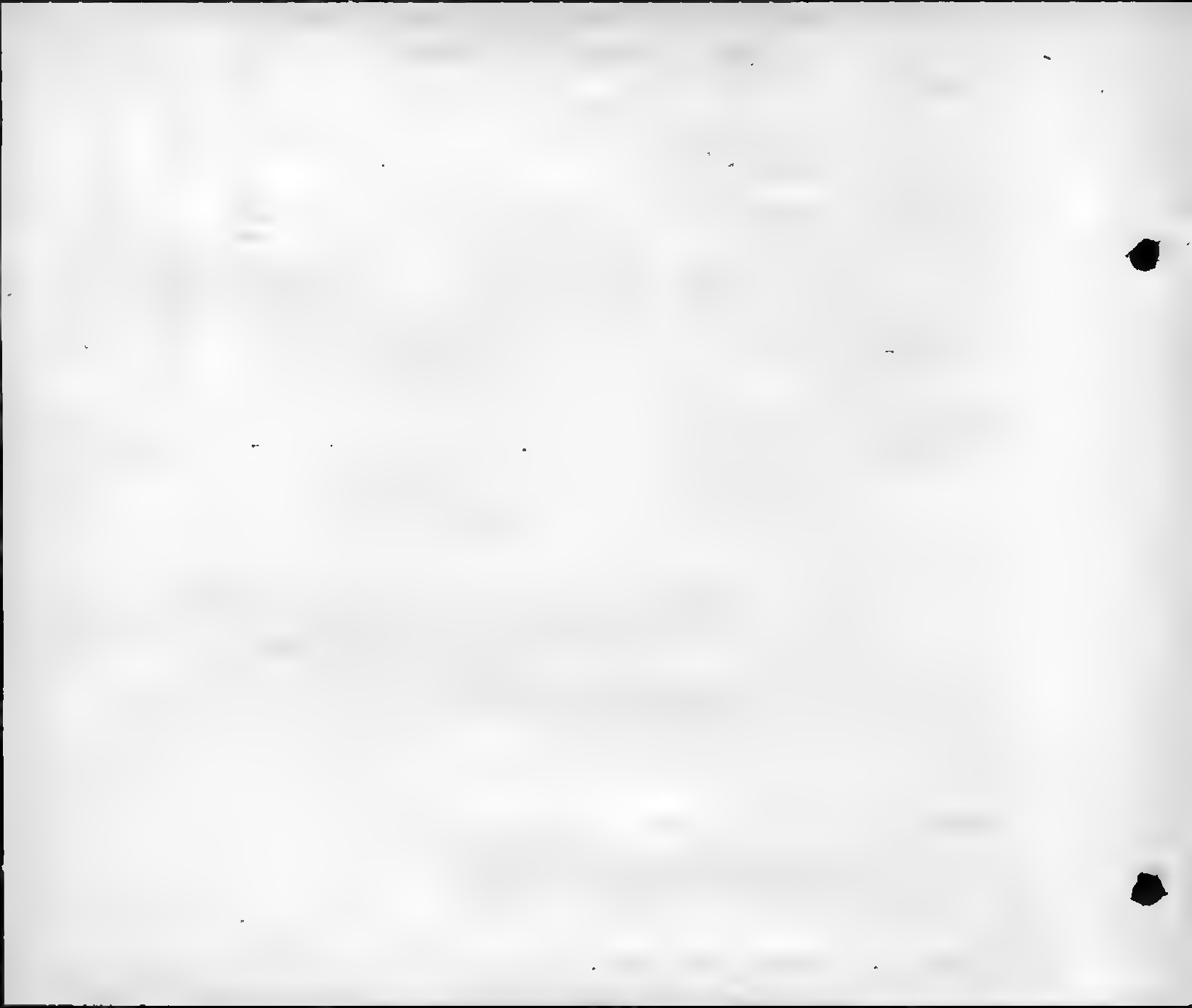
Reg. Dist. No.

03548

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sharon Nursing Home</b>		e. STREET ADDRESS <b>517 Beall Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Ambrose</b> Middle <b>E</b> Last <b>Parton</b>		4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/10/1888</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR: Months <b>9</b> Days <b>15</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William Parton</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Parton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>WW yes</b> <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Grace Parton-wife-same as 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis - Senility.</b>			
20a. ACCIDENT WAS (UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/25</b> 19 <b>59</b> to <b>3/25</b> 19 <b>60</b> , that I last saw the deceased alive on <b>3/18</b> 19 <b>60</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>C. H. Hinton M.D.</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. H. Hinton M.D.</b>		DATE SIGNED <b>3/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>BAR 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3448

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>18 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>723 RICHMOND AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
3. NAME OF DECEASED (Type or print) First <b>SARA</b> Middle <b>JANE</b> Last <b>PEDDICORD</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1873</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		11. IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		12. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>GEORGE NICHOLSON</b>			
14. MOTHER'S MAIDEN NAME <b>ELIZA MUSGROVE</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>Mr. Harold Peddicord, 723 Richmond Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>1950</b> to <b>3/1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/1</b> , 19 <b>60</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>906 Wilesville Rd. Silver Spring, Md.</b> DATE SIGNED <b>3/2/60</b> ACTUAL SIGNATURE <b>William D. Aud</b> M.D. PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b> 22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>3/4/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE CEMETERY</b> 22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Silver Spring, Md.</b> 24a. REC'D BY REGISTRAR <b>MAR 4 '60</b> 24b. REGISTRAR'S SIGNATURE							

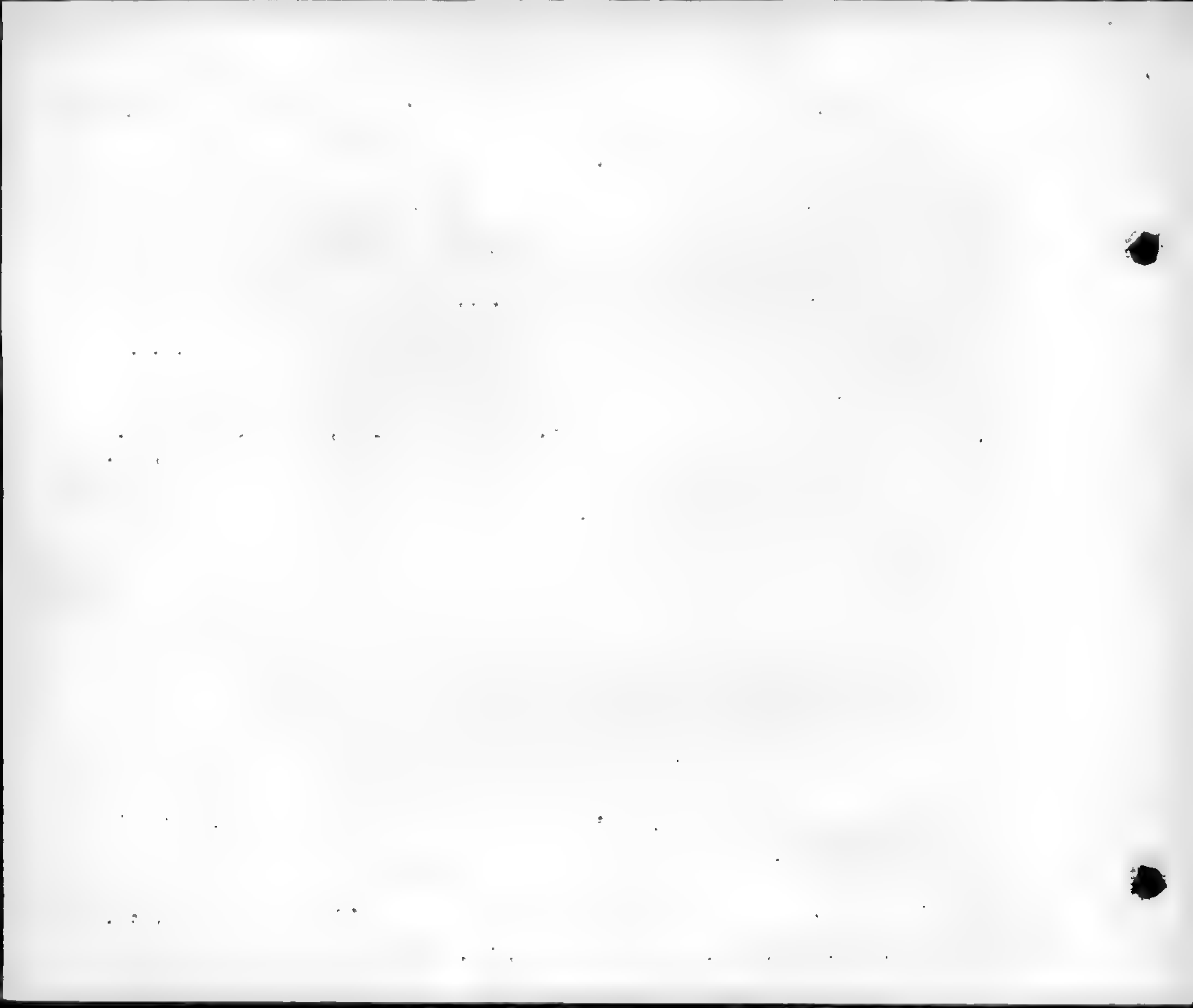
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3493

## CERTIFICATE OF DEATH

03550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>			
c. LENGTH OF STAY IN 1b <u>1 hr 10 min</u>				d. STREET ADDRESS <u>4404 71st Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp. Hl.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Everett Pendleton</u>				4. DATE OF DEATH Month Day Year <u>3 16 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-82</u>	9. AGE (In years last birthday) yrs <u>78</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>				13. FATHER'S NAME <u>Henry Clay Pendleton</u>			
14. MOTHER'S MAIDEN NAME <u>Helen Coons</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>578-05-3795</u>				17. INFORMANT <u>Patient's Chart - Wash. San. &amp; Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Silver Spring, Md.</u>				20g. (County) <u>Prince George's</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>				DATE SIGNED <u>3-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Nune Co. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03551

3500

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			c. LENGTH OF STAY IN 1b <b>27 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>58 Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 Grafton Street</b>				d. STREET ADDRESS <b>127 Grafton Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMILE</b> Middle <b>A</b> Last <b>PESSAGNO</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/21/1896</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Joseph P. Pessagno</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>578-34-4030</b>		17. INFORMANT <b>Elsie Pessagno, Wife, same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 Cardiac Arrest</b> DUE TO <b>Coronary Occlusion -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right Bundle Branch Block</b> DUE TO (c) <b>Acute Pancreatitis and Adrenal Insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>10 hrs.</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Pancreatitis and Adrenal Insufficiency</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December, 1950</b> , to <b>3/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/23</b> , 19 <b>60</b> , and that death occurred at <b>3:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Y. Jagers, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>5707 Wisconsin Ave Chevy Chase 15, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Frank Y. Jagers, Jr.</b>				DATE SIGNED <b>3/23/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

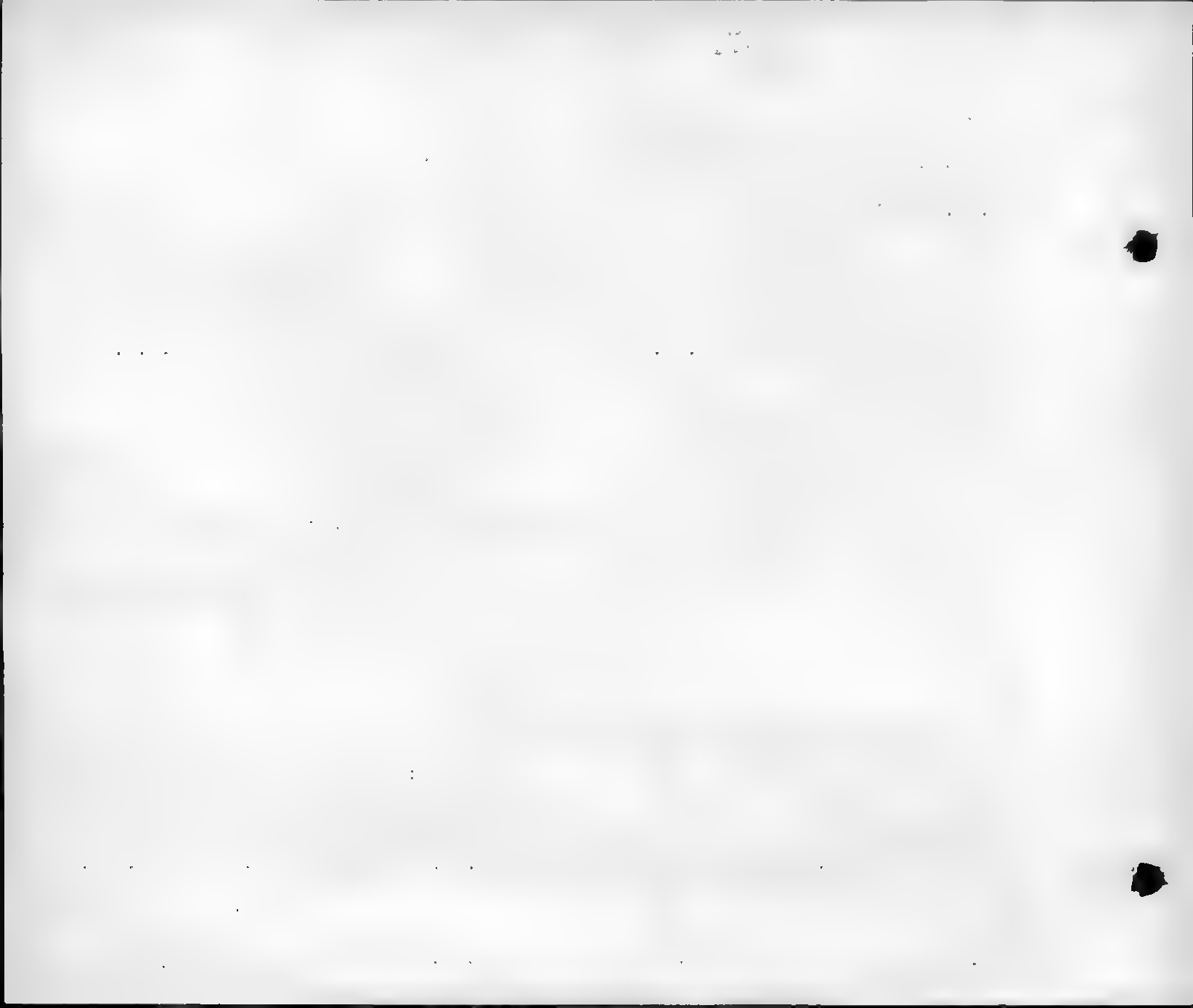
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3620

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03552

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Grove	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS - - - - -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Leo PIPER		4. DATE OF DEATH Month Day Year March 22 19 60	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-14	
9. AGE (In years lost birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh PIPER		14. MOTHER'S MAIDEN NAME Allie SANDIFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1941 to 1960	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197.9 DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pleural effusion and obstructive pulmonary emphysema. (c) Left retroperitoneal spinal fracture 5 mos prior		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 weeks 5 mos prior	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from December 29 1959, to March 22, 19 60, that (I) (we) last saw the deceased alive on March 21, 19 60, and that death occurred at 2:50 PM, from the causes and on the date stated above.			
22a. SIGNATURE R. T. Brooks		22b. DATE SIGNED 3-22-60	
22c. PHYSICIAN'S NAME (Type) R. T. BROOKS, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-23-60	
23c. NAME OF CEMETERY OR CREMATORY Lees Summit		23d. LOCATION (City, town, or county) (State) Lees Summit Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. NW, Washington, D.		25a. REC'D BY REGISTRAR MAR 24 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Krasner			



3449

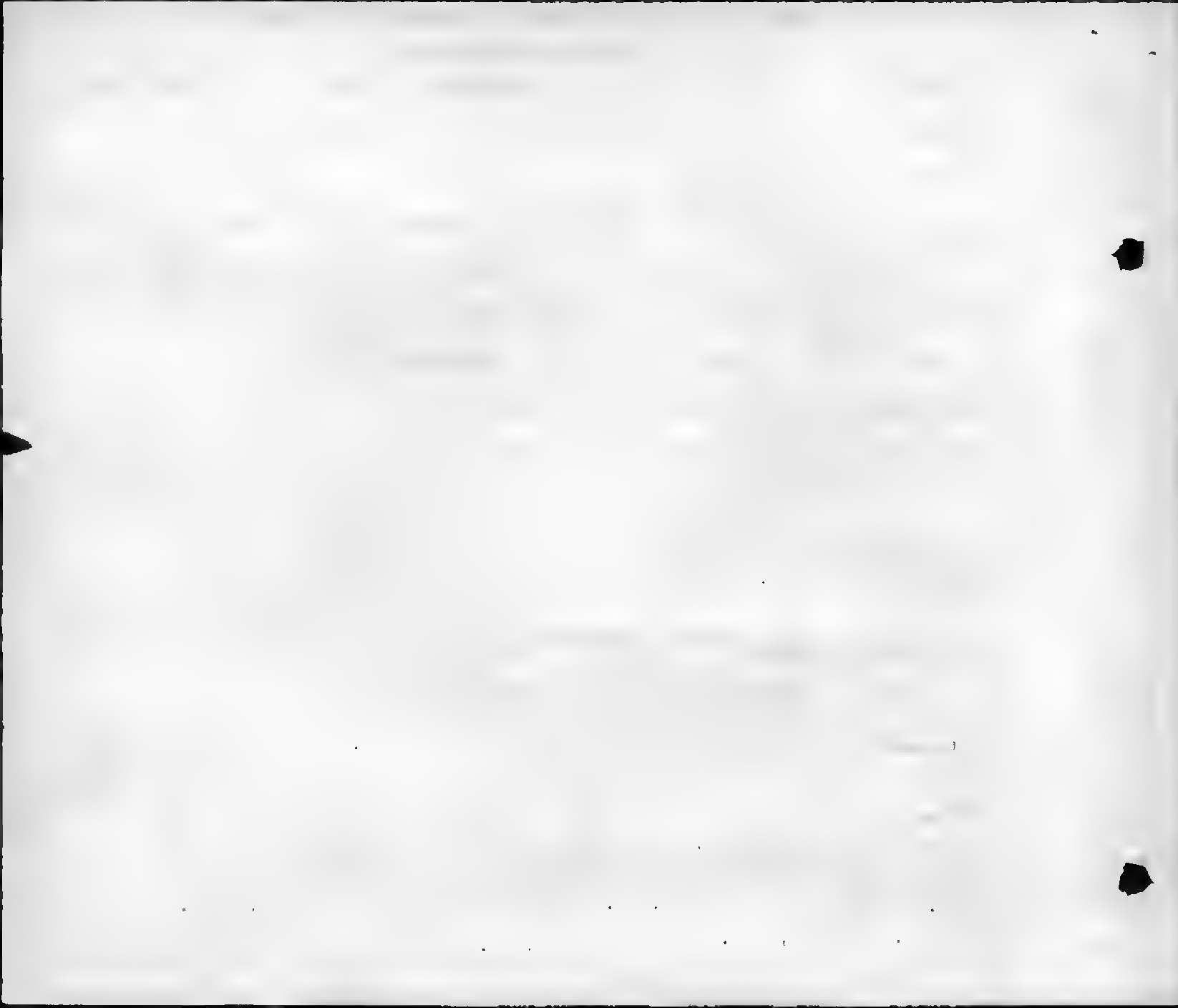
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8817 Glenville Road</i>		d. STREET ADDRESS <i>8817 Glenville Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>STEPHANIE PIUREK PLOCHARCZYK</i>		4. DATE OF DEATH Month Day Year <i>March 17 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 29, 1920</i>
9. AGE (In years last birthday) <i>39</i>		10. IF UNDER 1 YEAR: Months Days Hours Min. <i>39</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Internal Revenue</i>	
11. BIRTHPLACE (State or foreign country) <i>Connecticut</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>George Piurek</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Janda</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>048093849</i>	
17. INFORMANT <i>Walter Plocharczyk</i>		Address <i>8817 Glenville Rd. Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Ovarian carcinoma</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1959</i> , to <i>March 17, 1960</i> , that I last saw the deceased alive on <i>March 17, 1960</i> , and that death occurred at <i>8:30 A. M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. E. Silver Spring, Maryland</i>		DATE SIGNED <i>3/17/60</i>	
ACTUAL SIGNATURE <i>Elino Magi</i>		M.D. <i>Raymond A. Jirka</i>	
PHYSICIAN'S NAME (Type) <i>ELINO MAGI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. &amp; BURIAL</i>		22b. DATE THEREOF <i>3/19/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. ST. BENEDICT CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>HARTFORD, CONN.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Jirka</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>Raymond A. Jirka</i>		24b. REGISTRAR'S SIGNATURE <i>Raymond A. Jirka</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





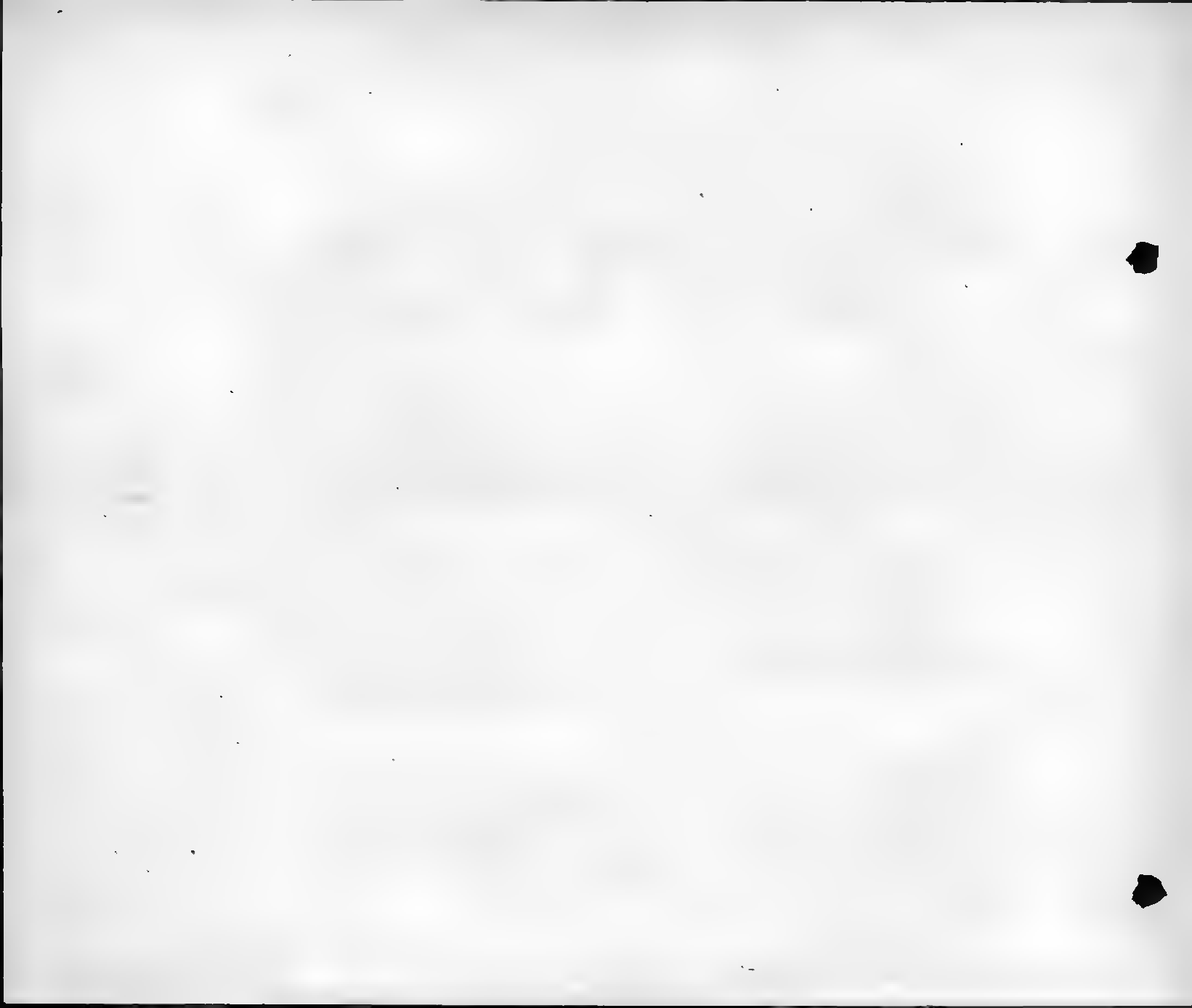
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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3401  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03554

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) L a. STATE <i>MD</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rockville San &amp; Hosp</i>		d. STREET ADDRESS <i>2211-42 NW</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thorne Kent Prentice</i>		4. DATE OF DEATH Month Day Year <i>3/17/60</i>	
5 SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 - 1877</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Charles Craven</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Altman</i>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Kent San &amp; Hosp records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Pulmonary Infarct</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Early Necrosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3/4/60</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>2/24/1960</i> to <i>3/13/1960</i> that (I) (we) last saw the deceased alive on <i>3/13/1960</i> and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Howard T. Morse</i> M.D.		22b. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		22d. ADDRESS <i>7030 Carnegie &amp; Tolson Park, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 17, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Baptist Church Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Chicamagua, Georgia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Mar 16 '60</i>	
ADDRESS <i>254 Carroll St. NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	



3621

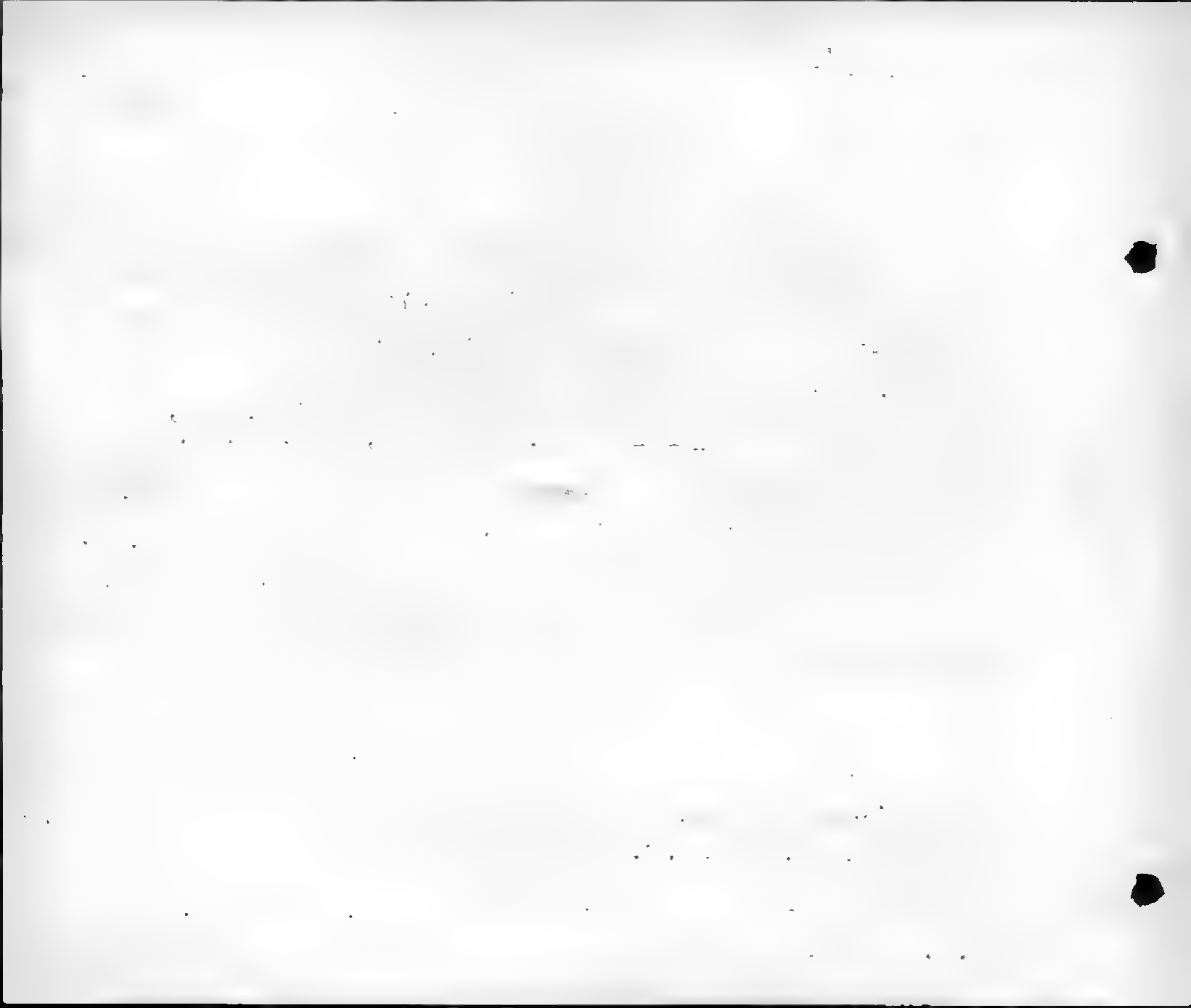
CERTIFICATE OF DEATH

03555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Matthews Nursing Home</b>		e. d. STREET ADDRESS <b>Hyattstown</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>CARVE</b> Last <b>PRICE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Nov 1879</b>
9. AGE (In years last birthday) yrs <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Price</b>		14. MOTHER'S MAIDEN NAME <b>Eunie Day</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-6200</b>	
INFORMANT <b>Dr. Warren Price, Kensington, Md.</b>		1616 Saul Road,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446x</b> DUE TO <b>Artemia, d</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Renal Disease</b> (c) <b>Generalized Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 years</b> <b>5 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>17 March, 1958</b> , to <b>17 March, 1960</b> , that I last saw the deceased alive on <b>16 March, 1960</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Barnesville, Md 17 March 60</b>	
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-19-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 21 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>	

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3.17 211mg240 4-4-60 et

Reg. Dist. No.

03556

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>18815 Seven Locks Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>George</u> Middle <u>Quiles</u> (Qualies)		4. DATE OF DEATH <u>3/28/1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>58</u> Days <u>28</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Quiles</u>		14. MOTHER'S MAIDEN NAME <u>Minerva Tally</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>529-163779</u>	
17. INFORMANT <u>Mattie Quiles</u> Address <u>(wife) same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (c) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Bruchant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-31-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>	22d. LOCATION (City, town, or county) (State) <u>FT MYER Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers G</u>		24a. REC'D BY REGISTRAR <u>3072-M-54 H.W.</u>	
		24b. REGISTRAR'S SIGNATURE <u>DATE MAR 29 '60</u>	

MEDICAL CERTIFICATION

DUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



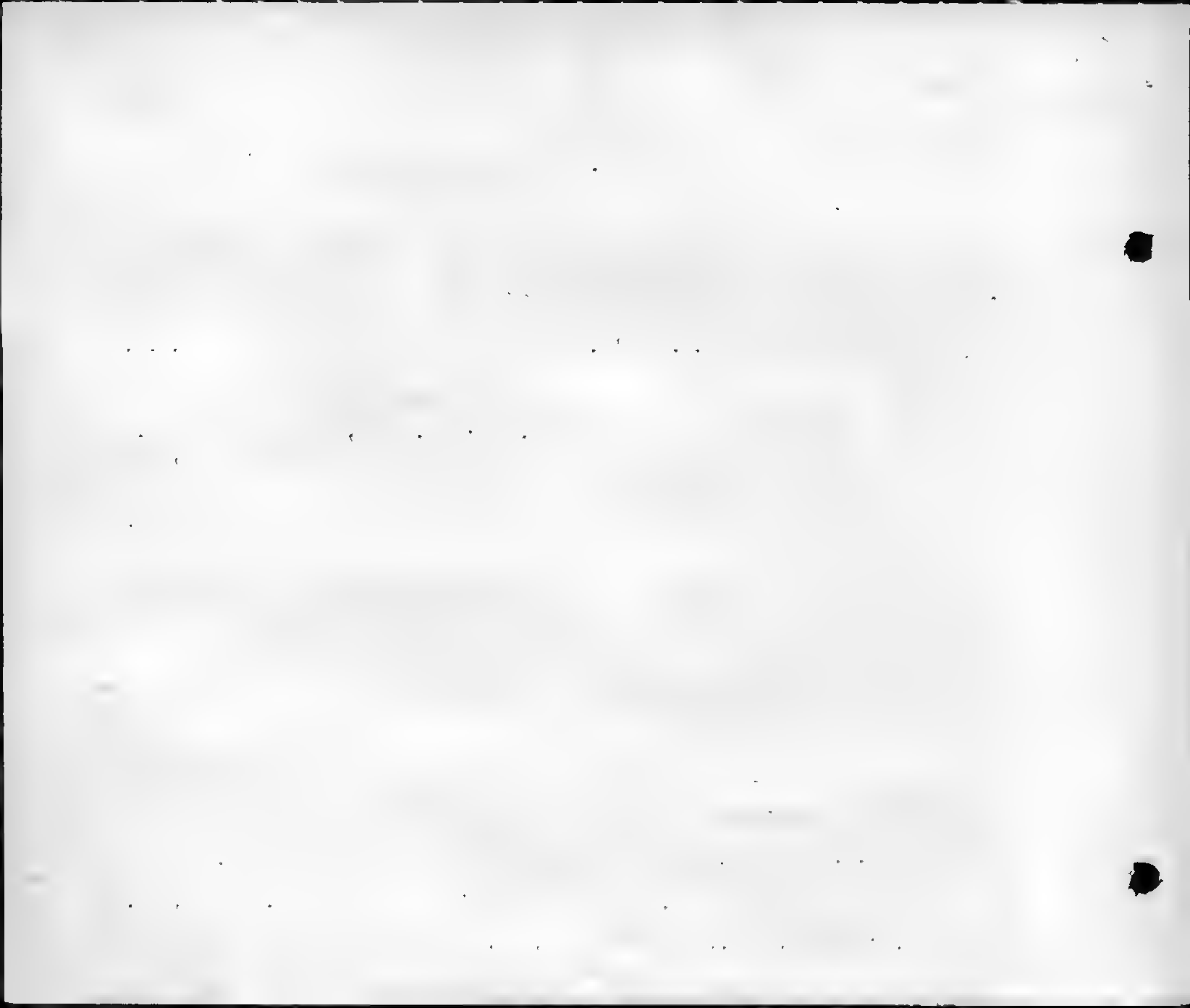
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03557

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8001 WOODBURY DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>D</b> Last <b>REID</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/85</b>
9. AGE (In years lost birthday, yrs) <b>75</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ichthyologist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>	
11. BIRTHPLACE (State or foreign country) <b>MISSISSIPPI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELMER REID</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE PASSENGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Grace E. Reid, 8001 Woodbury Dr.</b>		Address <b>Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial failure</b>			
4-2-1 DUE TO (b) <b>coronary insufficiency</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>X-Ray evidence Carcinoma of lung, probably metastatic</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-2-1944</b> to <b>3-8-1960</b> , that (I) (we) last saw the deceased alive on <b>3-8-1960</b> , and that death occurred at <b>1:50 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. S. Shoemaker, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>W. S. Shoemaker, M.D.</b>		22d. ADDRESS <b>8001 Woodbury Drive, S.S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Spec. fy) <b>BURIAL</b>		23b. DATE THEREOF <b>3/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 10 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1 746





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03558

## CERTIFICATE OF DEATH

Reg. Dist. No.

Birth Weight 2 lbs.

3620

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>705 EDMUNSTON AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CONNIE</b> Middle <b>MARIE</b> Last <b>RICE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 29 1960</b>
9. AGE (In years last birthday) yrs <b>10 13 10</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b> Hours <b>10</b> Min <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CARL JULIUS RICE</b>		14. MOTHER'S MAIDEN NAME <b>LOIS MERRY LANCASTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b> INFORMANT <b>MOTHER</b> Address <b>—</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>convulsions</b> DUE TO <b>10 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>heroin</b> DUE TO <b>10 days</b> (c) <b>prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hyperbilirubinemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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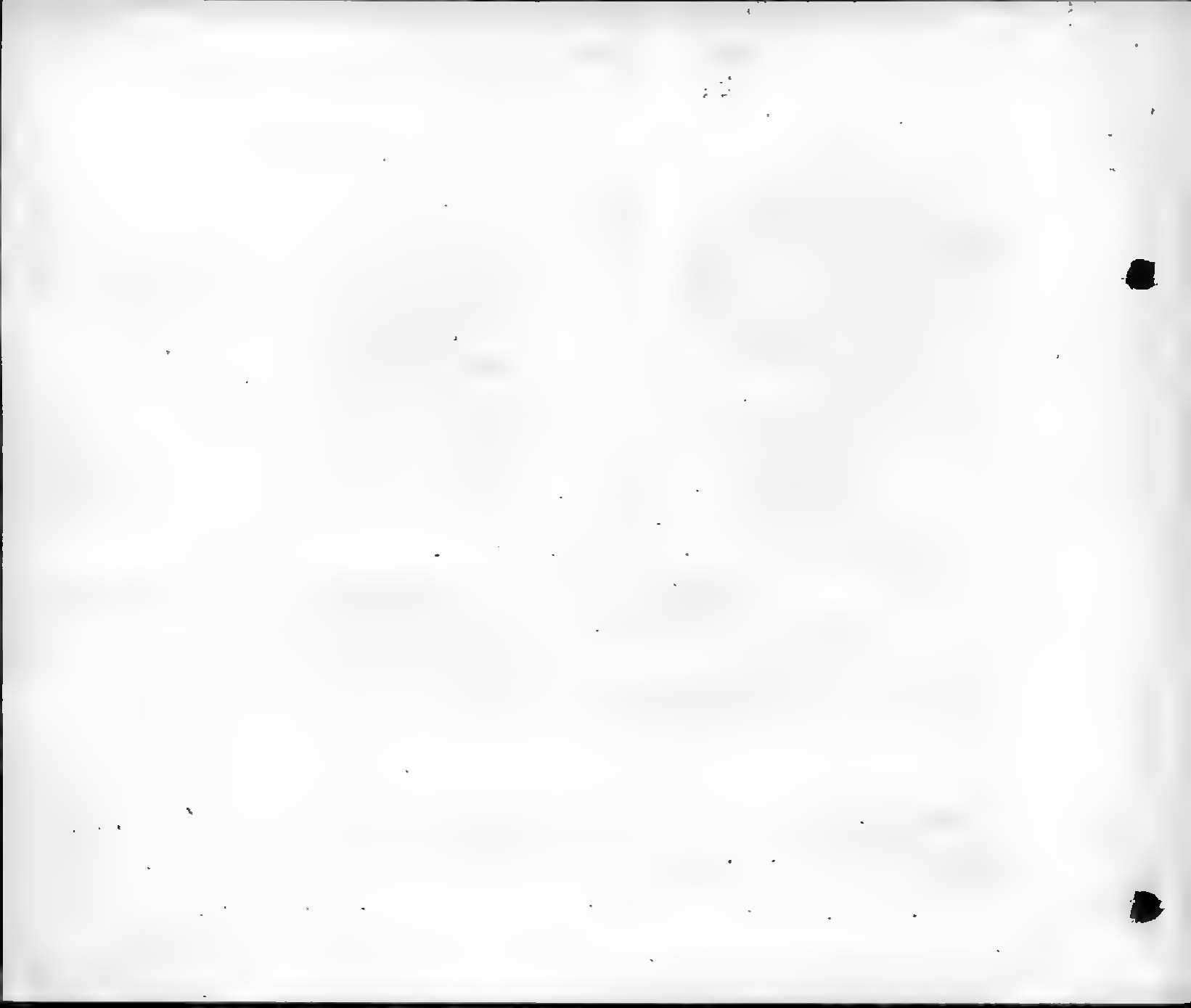
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from **2/29**, 19**60**, to **3/10**, 19**60**, that I last saw the deceased alive on **3/10**, 19**60**, and that death occurred at **7:10** A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE <b>Richard M. Auld</b>	M.D. <b>809 West North Street, Rockville, Md.</b>	DATE SIGNED <b>3/10/60</b>
PHYSICIAN'S NAME (Type) <b>Richard M. Auld</b>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Wheeler - Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3624

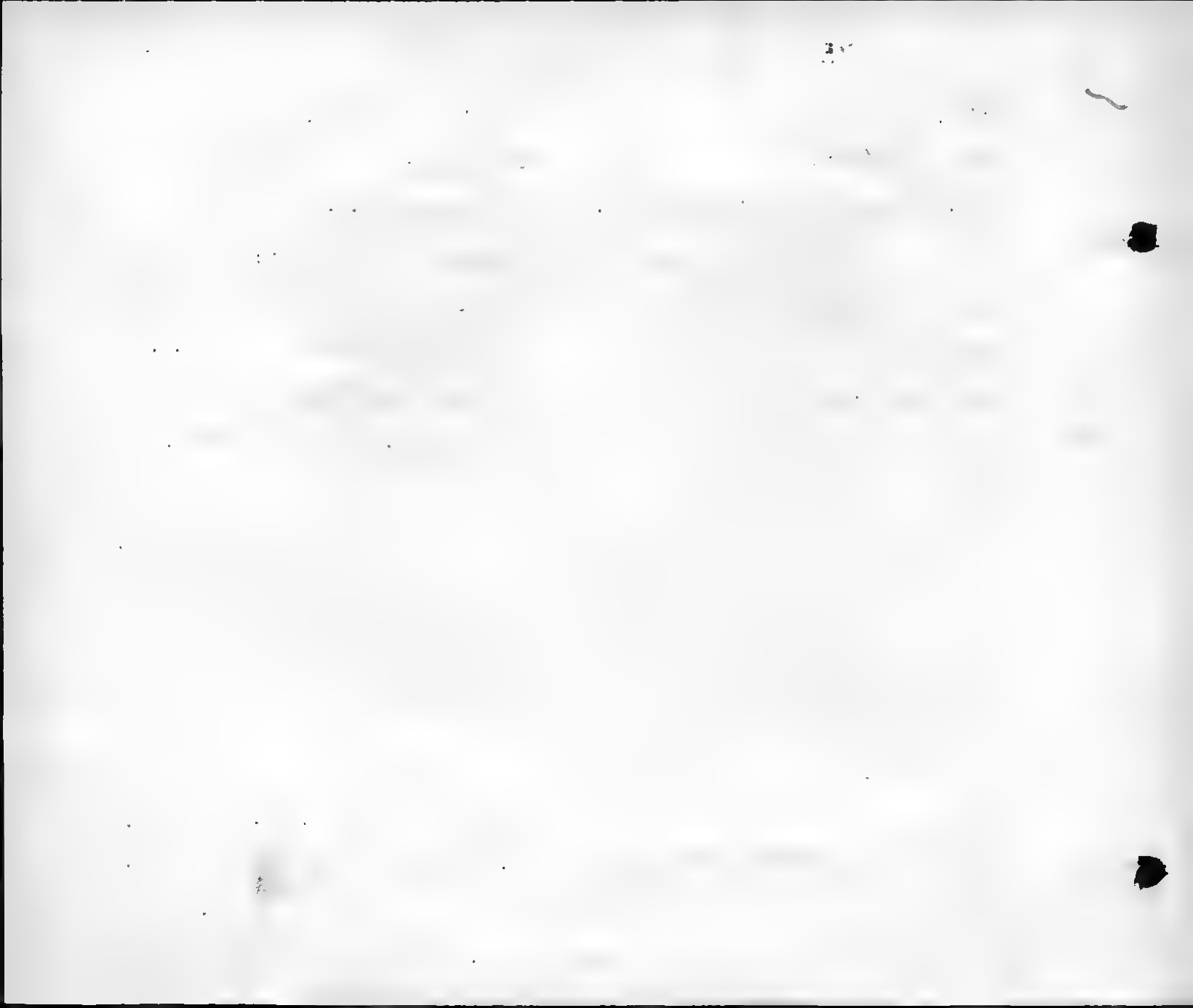
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-2</b> d. STREET ADDRESS <b>18 Jib Green S.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael John RICHARDS</b>				4. DATE OF DEATH Month Day Year <b>March 14 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-17-53</b>	
9. AGE (In years last birthday) yrs. <b>6</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>John Elbert RICHARDS</b>				14. MOTHER'S MAIDEN NAME <b>Jean Willa TUTTLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT (Father) <b>John E. Richards</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>510.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post-operative Tonsillectomy &amp; Adenoidectomy</b> DUE TO (c) <b>12 hrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>14 March 1960</b> to <b>14 March 1960</b> , that I last saw the deceased alive on <b>14 March 1960</b> , and that death occurred at <b>11:07 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>George W. Taylor Jr.</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>G.W. TAYLOR CDR MC USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

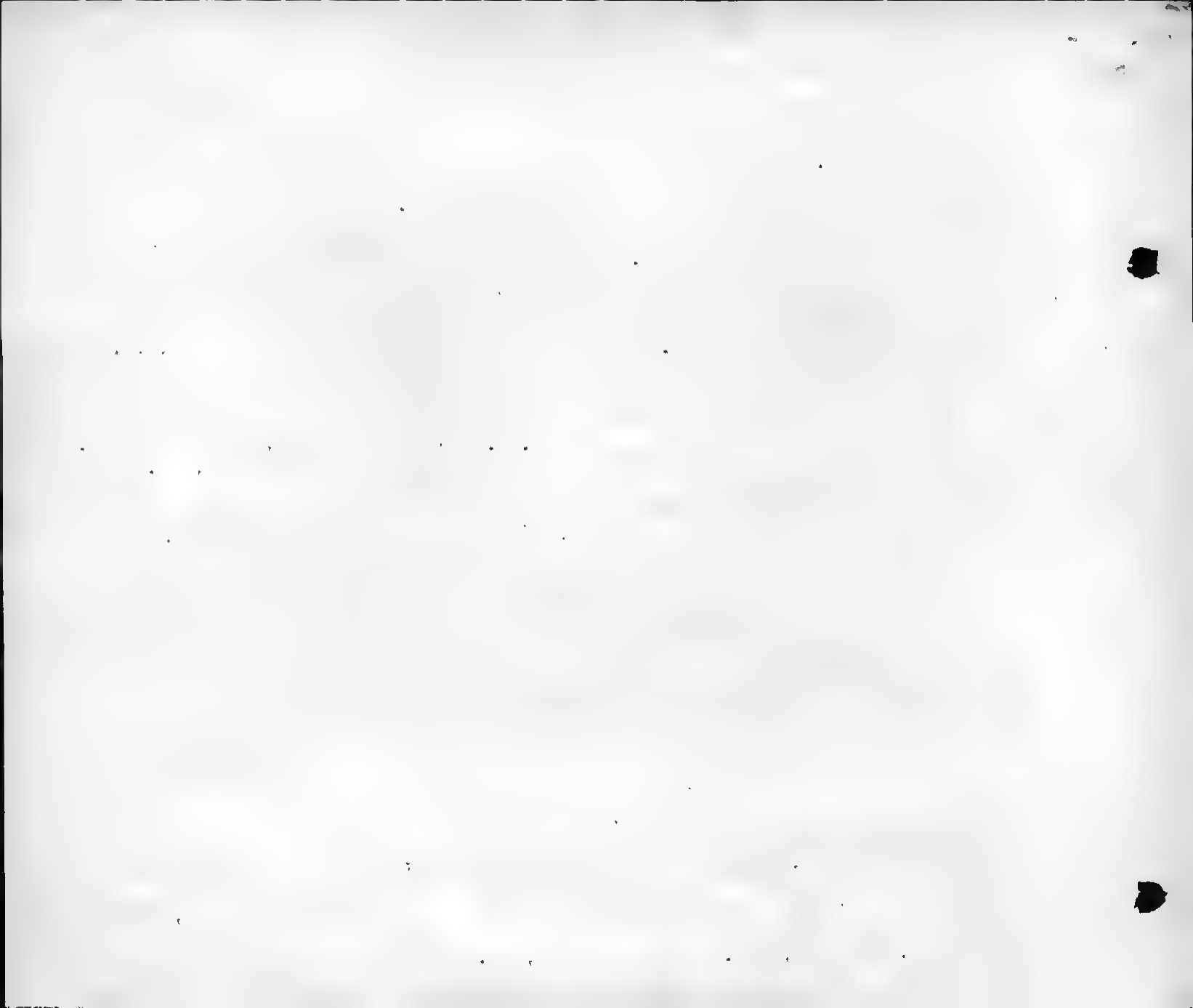
03560

3451

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Seymour Nursing Home</b>				e. STREET ADDRESS <b>2800 ELMORA STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>E.</b> Last <b>ROBERTS</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/1/81</b>		9. AGE (In years lost birthday) <b>79</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER BIERBAUER</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA RICKEMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. J. Benjamin Williams, 2800 Elnora St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c) <b>Cerebral Arterio Sclerosis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>2 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1960</b> to <b>March 12, 1960</b> that (I) (we) last saw the deceased alive on <b>March 12, 1960</b> , and that death occurred at <b>8 P M</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>John J. Curry MD</b>				22b. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>				22d. ADDRESS <b>10620 Georgia Ave Silver Spring</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/15/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond E. J. J. J.</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 15 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3625

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03561

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>Bethesda</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4610 West Virginia Avenue</b>			d. STREET ADDRESS <b>4610 West Virginia Ave</b>		
3. NAME OF DECEASED (Type or print) <b>Catherine Edith Robertson</b>			4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1883</b>		9. AGE (In years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S</b>			13. FATHER'S NAME <b>Charles H Campbell</b>		
14. MOTHER'S MAIDEN NAME <b>Simpronia Bond</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Samuel Robertson-husband-same as 2d</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>3/8/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 10 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>





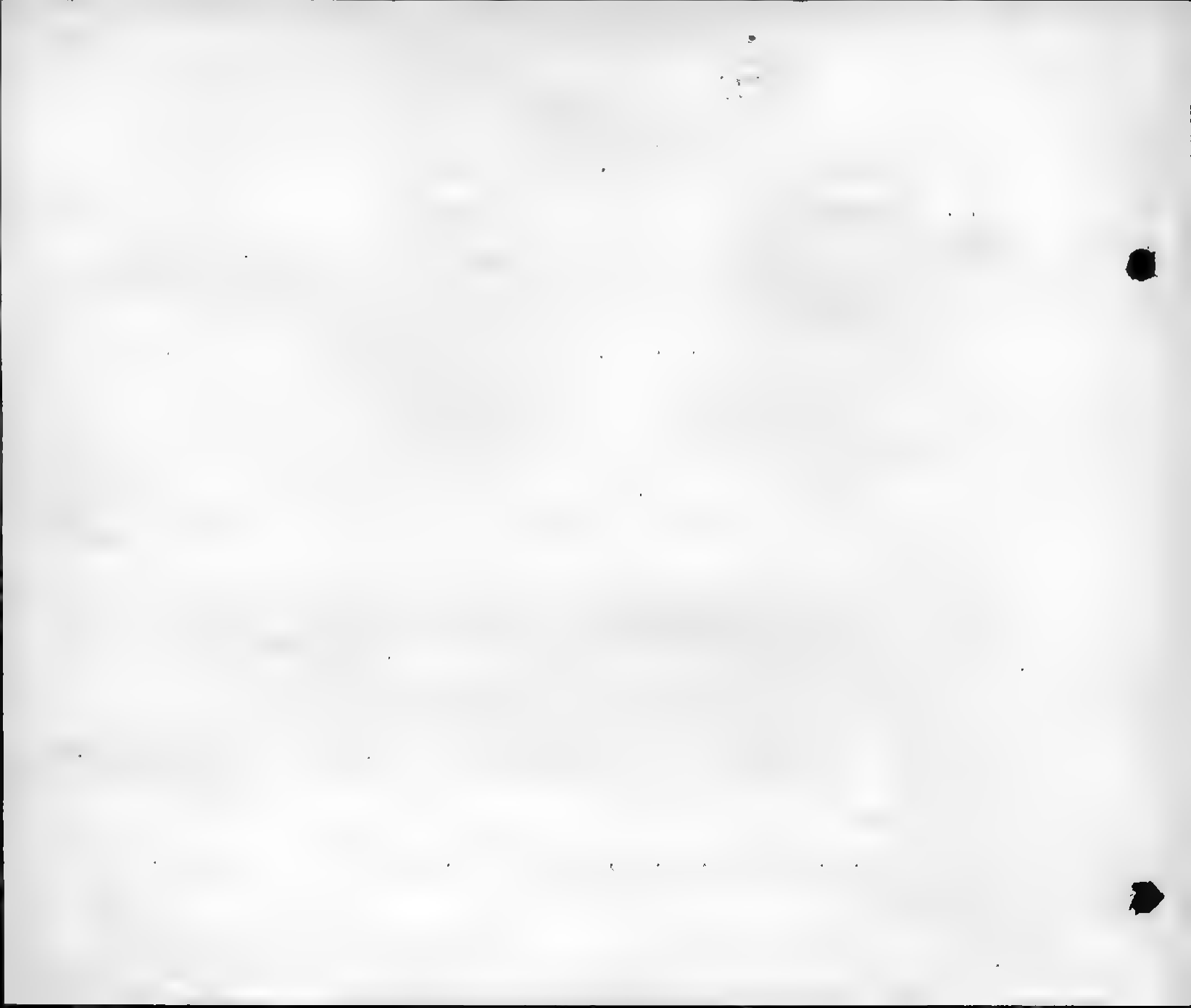
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3626

03562

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>92 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>New London</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New London</b> d. STREET ADDRESS <b>Maxson Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Eric SANDGREN</b>				4. DATE OF DEATH Month Day Year <b>March 24 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-84</b>	
9. AGE (In years last birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Carl A. SANDGREN</b>				14. MOTHER'S MAIDEN NAME <b>Evelina PETERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1903-1946</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart disease</b> DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Chronic atherosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia of right lung</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 month</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>XXXXXX</del> attended the deceased from <b>Dec. 23 1959</b> to <b>Mar. 24 1960</b> , that (1) <del>XXXX</del> last saw the deceased alive on <b>March 23 1960</b> , and that death occurred at <b>0435</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph E. Stitcher</b>				22b. DATE SIGNED <b>3-24-60</b>		22c. PHYSICIAN'S NAME (Type) <b>J. E. STITCHER, LT, MC, USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S. H. Hines Co., 2901 14th St., NW, Wash. D. C.</b>				25a. REC'D BY REGISTRAR <b>MAR 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3627

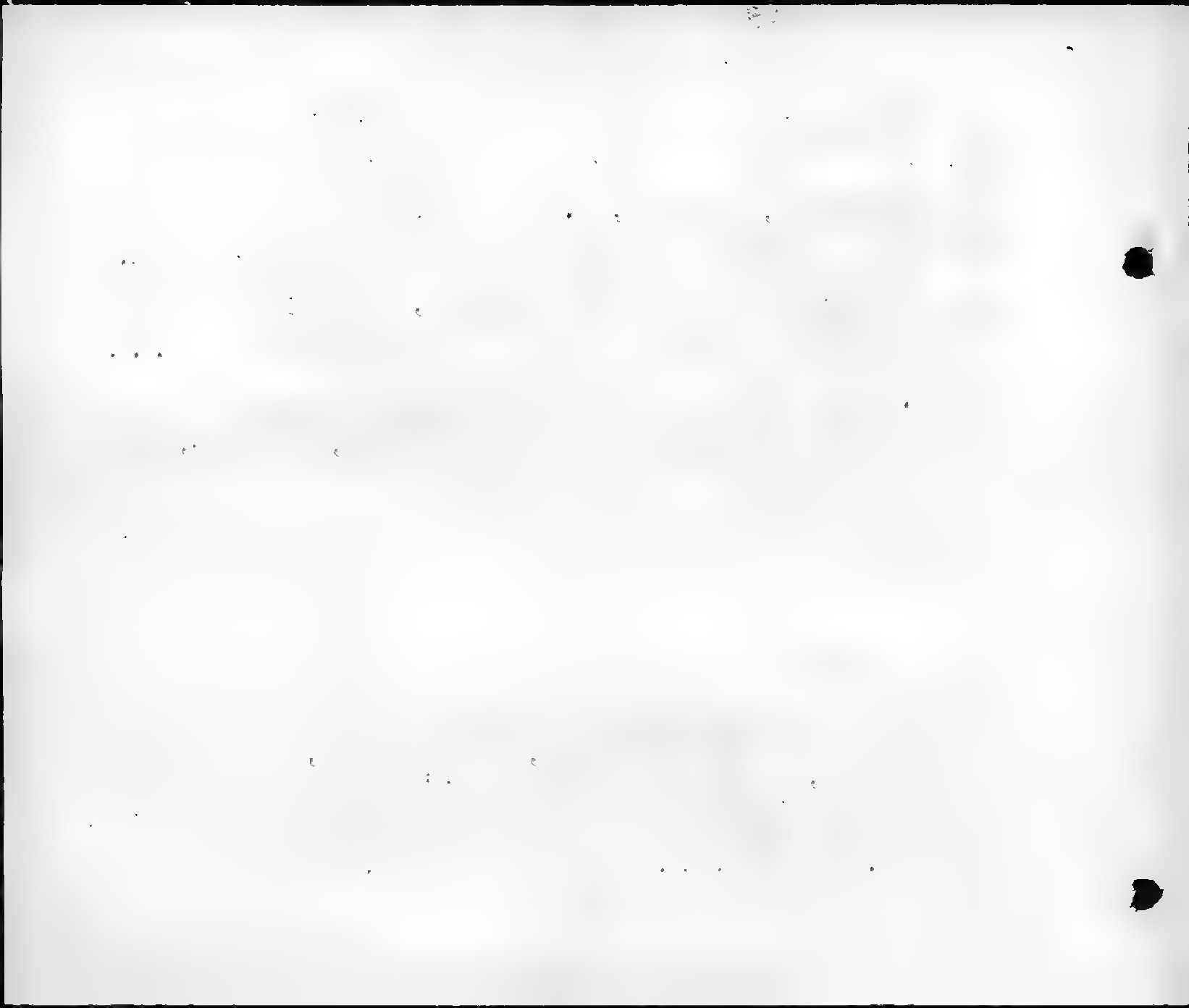
CERTIFICATE OF DEATH

Reg. Dist. No.

04754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN II <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Travelers Rest</b> 77X-3			
3. NAME OF DECEASED (Type or print) First <b>Montez</b> Middle <b>Jerrell</b> Last <b>Sanford</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 6, 1946</b>	
9. AGE (In years last birthday) <b>13</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
13. FATHER'S NAME <b>James C. Sanford</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Coody</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Postoperative State</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Disease</b> DUE TO (c) <b>Ventricular Septal Defect and Pulmonic Stenosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>Birth</b> <b>Birth</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that I attended the deceased from <b>March 20, 1960</b> to <b>March 31, 1960</b> that I last saw the deceased alive on <b>March 31, 1960</b> and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center April 1, 1960</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>E. Kent Carney</b> M.D. PHYSICIAN'S NAME (Type) <b>E. Kent Carney, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-1-60</b>		22b. DATE THEREOF <b>4-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenville County, So. Car.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1. The first of these is the

2. The second is the

3. The third is the

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3495 CERTIFICATE OF DEATH

03564

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Schirmer</u> Middle <u>Charles</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Schirmer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Nagengast</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Chart</u>	
17. INFORMANT <u>Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Branchogenic carcinoma, left</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>5 months</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Nephemia</u> <u>2. Arteriosclerotic heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1958</u> to <u>25 March 1960</u> , that (I) (we) last saw the deceased alive on <u>25 March 1960</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lenoch T. Kintle</u> M.D.		22b. DATE SIGNED <u>25 March 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. Kintle</u>		22d. ADDRESS <u>929 Pershing Drive, Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/29/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hines Co.</u> ADDRESS <u>2901-18th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>MAR 28 60</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

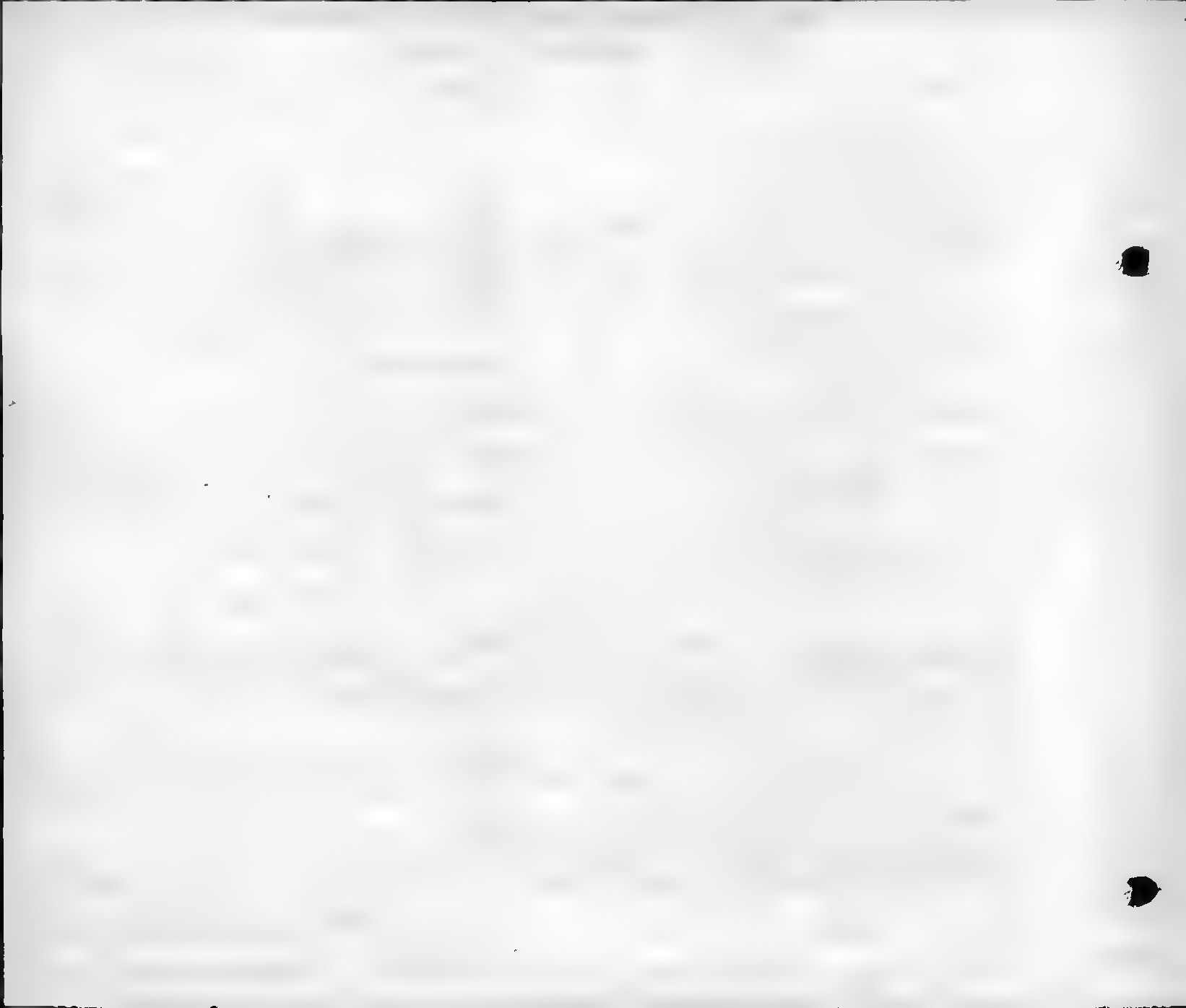
3486

## CERTIFICATE OF DEATH

Reg. Dist. No.

03565

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3-16 -33-56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>1200 Caddington</u>			
3 NAME OF DECEASED (Type or print) <u>GOLDIE</u> First <u>SCHNEIDER</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-4-27</u>		9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store - Hardware</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware business</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Kessler</u>				14. MOTHER'S MAIDEN NAME <u>Ida Seigel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-48-6910A</u>		17. INFORMANT <u>Chart record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL ANEURYSM Aorta</u> <u>451X</u> DUE TO <u>DISSECTING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO <u>SENILITY</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE (2) BILATERAL PLEURAL EFF.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SIOWLY</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>AUG 29</u> , 19 <u>59</u> , to <u>MARCH 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>60</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8829 FLOWER AVE. SILVER SPRING Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>				<u>SILVER SPRING Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATH. CAP. HEBREW CON</u>		22d. LOCATION (City, town, or county) (State) <u>DENNING'S, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shelley Funeral Home</u> ADDRESS <u>4217-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3452  
**CERTIFICATE OF DEATH**

03566

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taberna Park</u>		c. LENGTH OF STAY IN 1b since Sept. <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San &amp; Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Elton Schroeder</u>		4. DATE OF DEATH Month Day Year <u>March 16 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-32</u>
9. AGE (In years last birthday) <u>27</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>P.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Delbert L. Schroeder</u>		14. MOTHER'S MAIDEN NAME <u>Lydia L. Chandler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Wash San &amp; Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1730 Pneumonia</u> DUE TO <u>Carcinomatosis</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>primary medulloblastoma cerebellum</u> DUE TO <u>primary medulloblastoma cerebellum</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>21 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>March 16 1960</u> that (I) (we) last saw the deceased alive on <u>March 15 1960</u> and that death occurred <u>4:55 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Henry W. Stout</u> M.D.		22b. DATE SIGNED <u>March 18 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. W. STOUT MD</u>		22d. ADDRESS <u>10011 GEORGIA AVE SILVER SPRING MD.</u>	
23a. BURIAL CREMATION REMOVAL (Spec. fy) <u>BURIAL</u>	23b. DATE THEREOF <u>3/21/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 18 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION



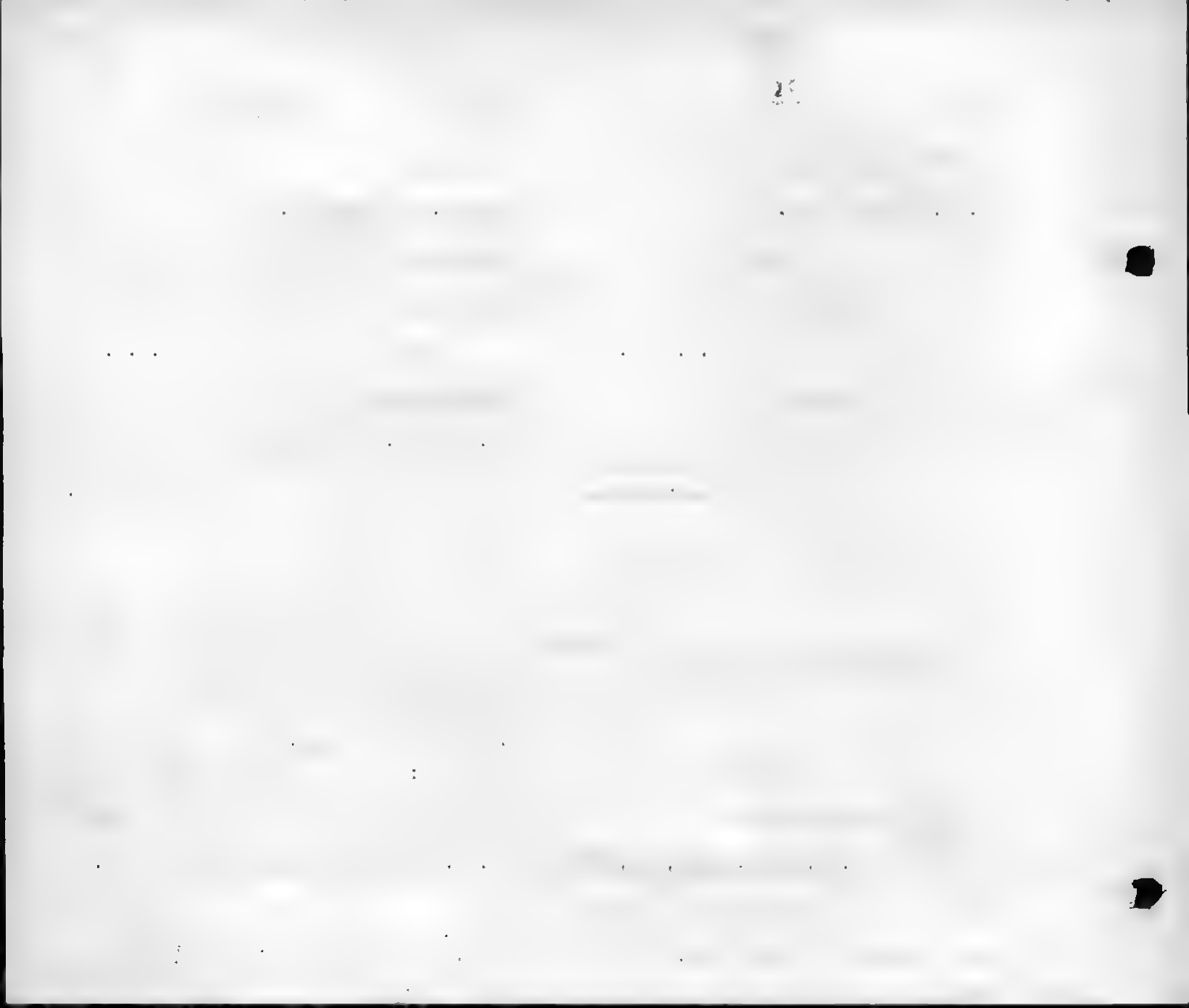
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3623  
CERTIFICATE OF DEATH  
03567

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>3279 S. Stafford St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>SCHROELL</b> Last <b>SCHROELL</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>19 60</b>													
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-12-92</b>		9. AGE (In years, lost birthday) <b>67</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Govt.</b>				11. BIRTHPLACE (State or foreign country) <b>Kansas</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>Frederick SCHROELL</b>						14. MOTHER'S MAIDEN NAME <b>Ann URQUHART</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>1908-1922</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(W) Mrs. Mary J. Schroell, same as #2 above</b> Address									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Astrocytoma, grade iii</b> <b>193.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 mos.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <b>193.9</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>March 24, 1960</b>		(County) <b>March 29, 1960</b>		(State) <b>xx</b>			
21 I certify that (I) <del>(the doctor)</del> attended the deceased from <b>March 24, 1960</b> to <b>March 29, 1960</b> , that (I) <del>(the doctor)</del> last saw the deceased alive on <b>March 29, 1960</b> , and that death occurred at <b>2:45 p.m.</b> from the causes and on the date stated above															
22a. SIGNATURE <b>M. W. Wood</b>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3-29-60</b>							
22c. PHYSICIAN'S NAME (Type) <b>M. W. WOOD, ICDR, MC, USN</b>						22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>					
24 FUNERAL DIRECTOR'S SIGNATURE <b>Everly Wheatley Funeral Home</b>						ADDRESS <b>Alexandria, Va.</b>		25a. REC'D BY REGISTRAR <b>APR 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>					



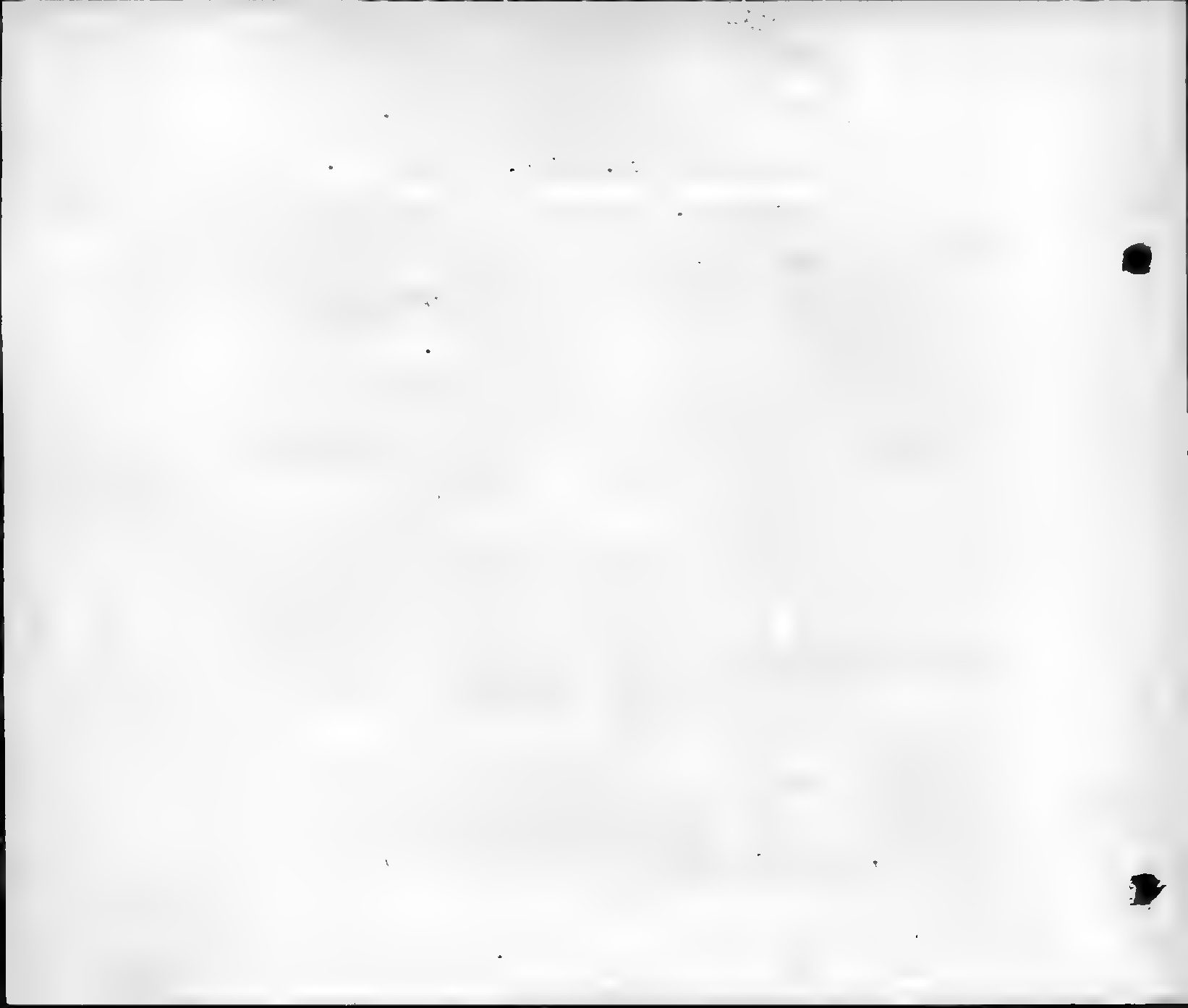
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
not retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3629 CERTIFICATE OF DEATH

03568

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>olney</b>		c. LENGTH OF STAY IN 1b <b>13 hrs. 45mins.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rt. 2 Gaitnersburg</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amanda Jane</b> Middle <b>Seal</b> Last <b>Seal</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/1880</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenn.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lafayette Rhea</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X Cerebral Hemorrhage</b> DUE TO <b>Cardio-Vascular Disease</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertension</b> DUE TO <b>Hypertension</b> (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> or Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1935</b> to <b>March 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>3/6/1960</b> , and that death occurred at <b>1:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M. M. Kendree Boyer</b>		22b. DATE SIGNED <b>March 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. M. Kendree Boyer</b>		22d. ADDRESS <b>Damascus, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 10</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Seal Farm Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Etchison Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis A. Barber</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Oliver S. Hanna</b>	





3630

## CERTIFICATE OF DEATH

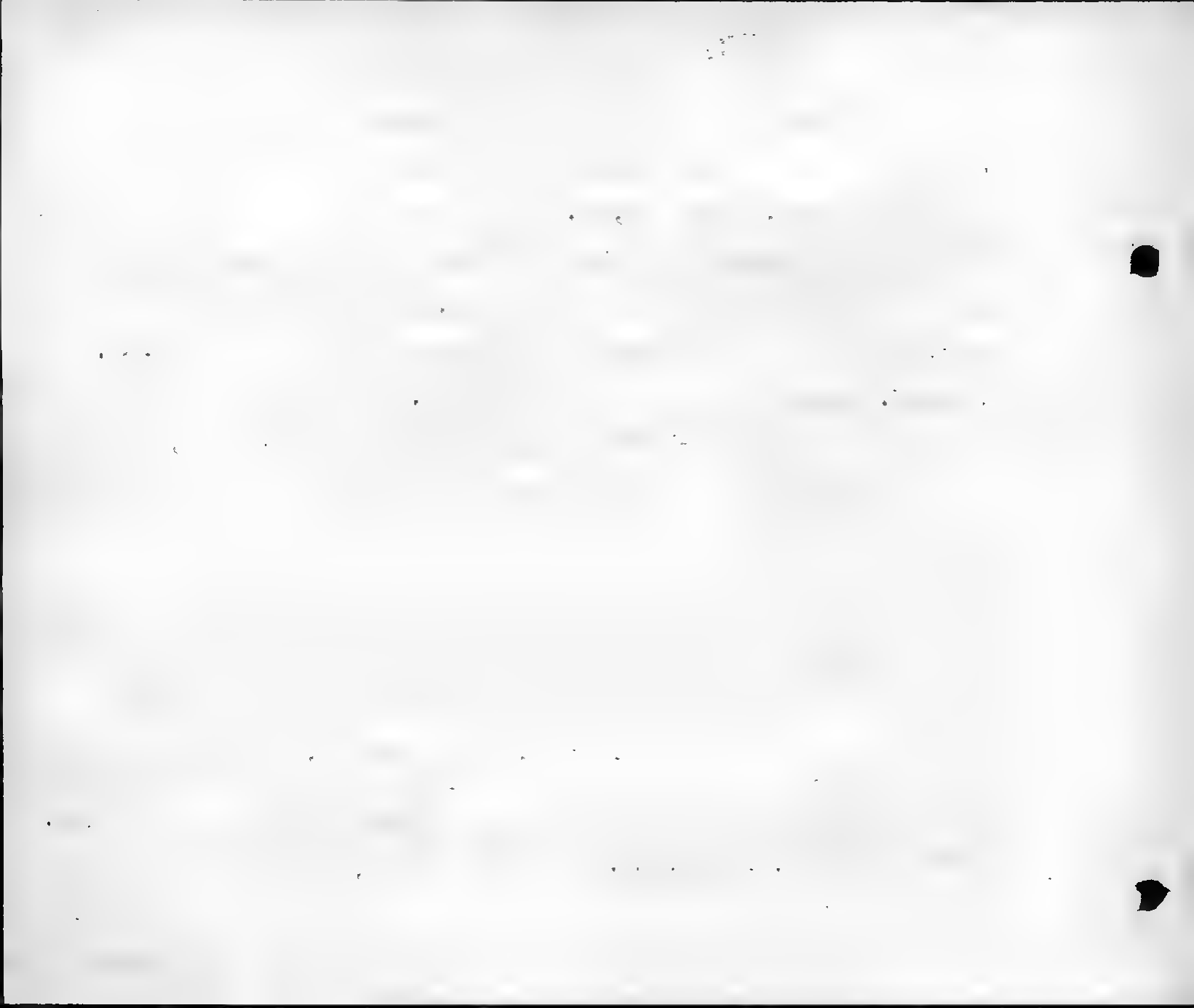
03563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>80 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b> <b>724</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>RFD #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edwin</b> Last <b>Seebode</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1937</b>		9. AGE (In years last birthday) <b>22</b> yrs	IF UNDER 1 YEAR Months <b>22</b> Days <b>23</b> Hours <b>19</b> Min <b>60</b>	IF UNDER 24 HRS Hours <b>19</b> Min <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond W. Seebode</b>				14. MOTHER'S MAIDEN NAME <b>Edith A. Johnston</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-8876</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>January 3, 1960</b> to <b>March 23, 1960</b> , that I last saw the deceased alive on <b>March 23, 19 60</b> , and that death occurred at <b>3:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>March 23, 1960</b> ACTUAL SIGNATURE <b>CA Chidsey</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>Charles A. Chidsey, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL CREMATION REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>3/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SI-YERBROOK</b>		22d. LOCATION (City, town, or county) (State) <b>WILMINGTON DEL</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burlage</b>				ADDRESS <b>Berlin Md</b>		24a. REC'D BY REGISTRAR <b>MAR 30 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3631

## CERTIFICATE OF DEATH

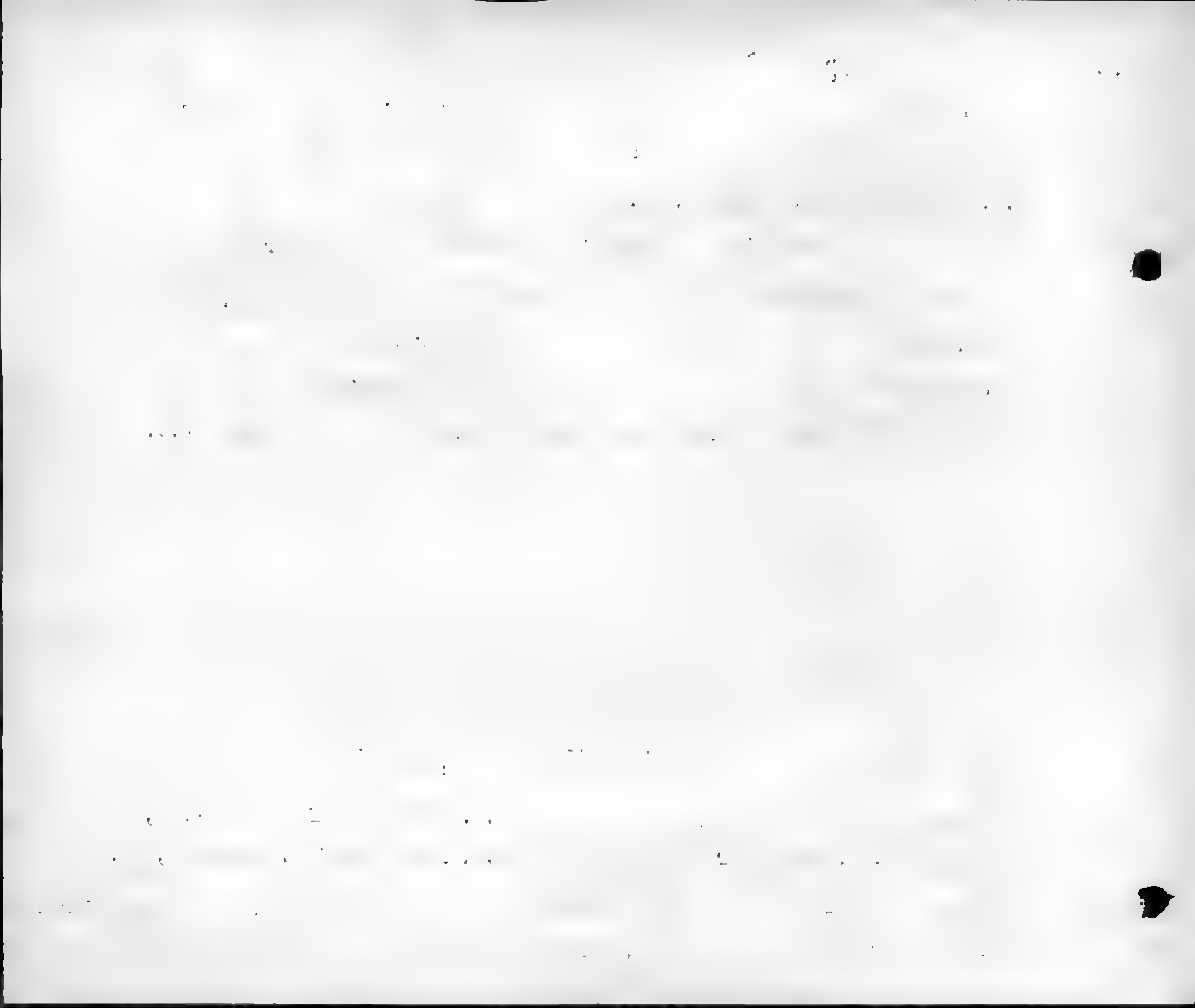
03570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) F. Institution, Residence before admission) b. STATE <b>North Carolina</b> c. COUNTY <b>Dare</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>77 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Franklin</b> Last <b>SHANNON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-16</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Shannon SR</b>		14. MOTHER'S MAIDEN NAME <b>Sammy Jane Baum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>1937-1941</b>	
17. INFORMANT <b>Lula R Shannon</b>		Address <b>Manteo, N.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, large bowel</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>19 December 1959</b> to <b>5 March 1960</b> , that I last saw the deceased alive on <b>5 March 1960</b> , and that death occurred at <b>9:23 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James M. Young</b>		ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL BETHESDA, MD</b>	
PHYSICIAN'S NAME (Type) <b>J. M. YOUNG LT MC USN</b>		DATE SIGNED <b>3-5-60</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manteo Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Manteo Dare North Carolina</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3498

## CERTIFICATE OF DEATH

Reg. Dist. No.

03571

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thomson Park</u>		c. LENGTH OF STAY IN 1b <u>16 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>527 Somerset Pl NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>(NNN)</u> Middle <u>SHENK</u> Last			4. DATE OF DEATH <u>March 15</u> 19 <u>60</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-80</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Abraham Sherr</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular-renal disease</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>50</u> , to <u>Mar 15</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 14</u> 19 <u>60</u> , and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Simon C. Weiner</u>		M.D. <u>100 Longfellow St NW Wash DC</u>		DATE SIGNED <u>3/15/60</u>	
PHYSICIAN'S NAME (Type) <u>SIMON C. WEINER</u>					
22a. BURIAL, CREMATION, REMOVE (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELESABETGRAD CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Son</u>		ADDRESS <u>3501-14 St NW Wash DC</u>	24a. REC'D BY REGISTRAR <u>DATE MAR 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



## 3632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

File G261 4-23-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rockville R-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>Scotland</u>			
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Shepard</u> Last <u>Shepard</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?		
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?			
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY ?			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? <u>V</u>		16. SOCIAL SECURITY NO. ?			
17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>                    </u> (a), stating the underlying cause lost, (c) <u>                    </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>				INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>University of Medicine &amp; Dentistry</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Broschert</u>		24a. REC'D BY REGISTRAR <u>                    </u>			
ADDRESS <u>108 N. Washington St. Rockville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			
DATE <u>APR 1 '60</u>					

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





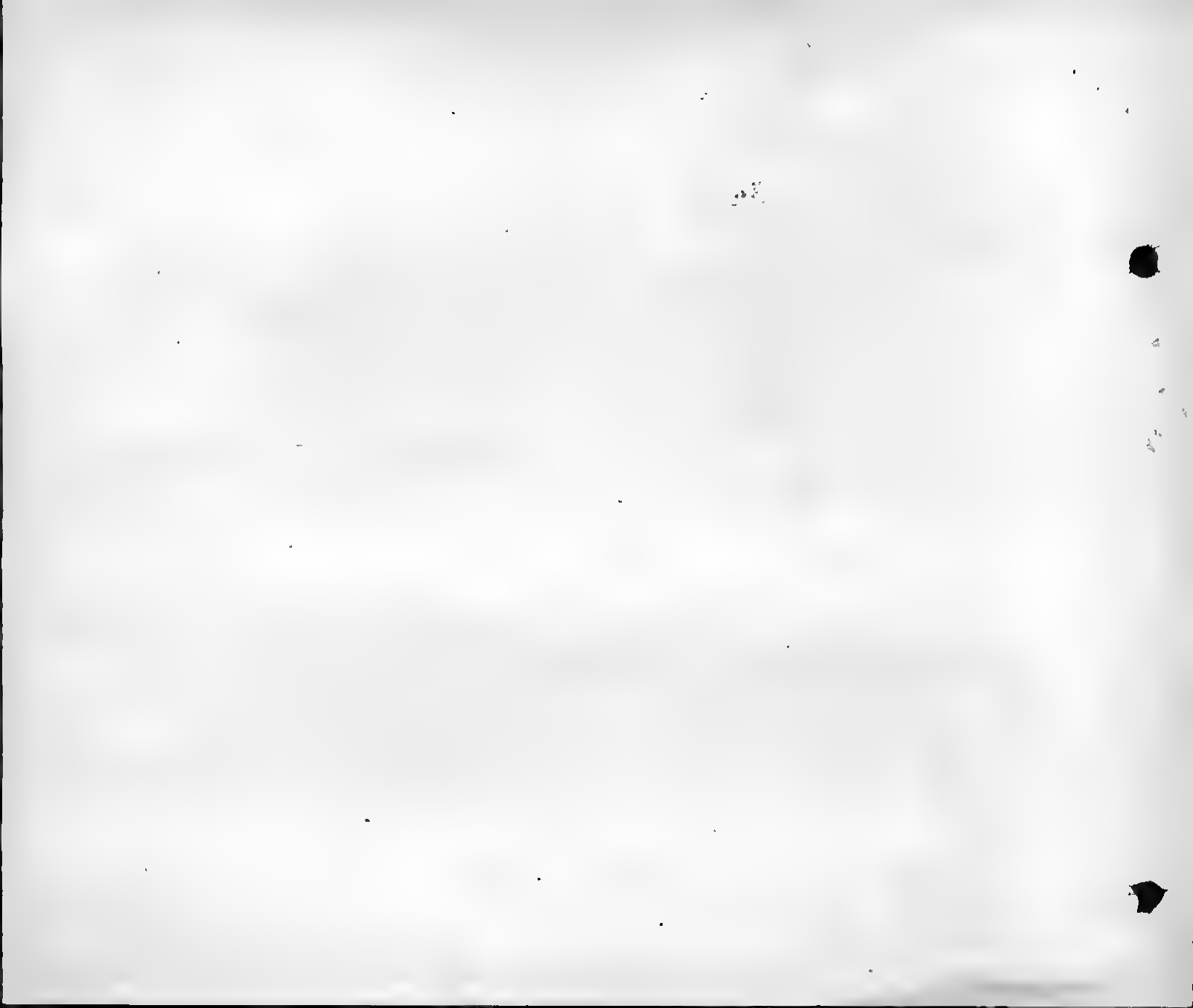
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 Form 10-3-10-60 et  
3633  
CERTIFICATE OF DEATH

03573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Alexandria</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria Virginia</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Respected Lane</i>		d. STREET ADDRESS <i>1225 Stafford Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Dr. Joseph</i> Middle <i>Walter</i> Last <i>Shohan</i>		4. DATE OF DEATH Month <i>3</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 22 1914</i>
9. AGE (In years last birthday) <i>45</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <i>Physician</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
13. FATHER'S NAME <i>William Shohan</i>		14. MOTHER'S MAIDEN NAME <i>Hannah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		17. INFORMANT Address <i>Charles F Shohan—same as 2d</i>	
16. SOCIAL SECURITY NO. <i>None</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>carcinoma of sigmoid with general metastasis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/13</i> 19 <i>60</i> to <i>3/4</i> 19 <i>60</i> that I last saw the deceased alive on <i>2/23</i> 19 <i>60</i> , and that death occurred at <i>5:4</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4840 Bull Run Lane, Bethesda</i> DATE SIGNED <i>3/4/60</i>			
ACTUAL SIGNATURE <i>Walter R. Ehrmantraut M.D.</i>			
PHYSICIAN'S NAME (Type) <i>Walter R. Ehrmantraut M.D.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/8/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Comfort Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Alexandria, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Rumphrey</i> ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>7 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

03574

3489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1808 Conn. Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Clarinda Shorey</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-11-84</u>	
9. AGE (In years last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>		IF UNDER 24 HRS Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Burkart</u>				14. MOTHER'S MAIDEN NAME <u>Lizabeth Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>2</u>			
17. INFORMANT <u>Mrs. John C. Bahr, Philadelphia, Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole - Complete Heart Block</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis + Hypertension Heart Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis &amp; Infarction, Nephrosclerosis</u> <u>Gout</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/17</u> , 19 <u>60</u> , to <u>3/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>60</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Ruth B. Benedict M.D.</u>				ADDRESS (Street, city or town, state) <u>1808 Conn. Ave. N.W. Wash. D.C.</u>			
DATE SIGNED <u>3/12/60</u>							
PHYSICIAN'S NAME (Type) <u>RUTH B. BENEDICT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St. N.W.</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Rine</u>							

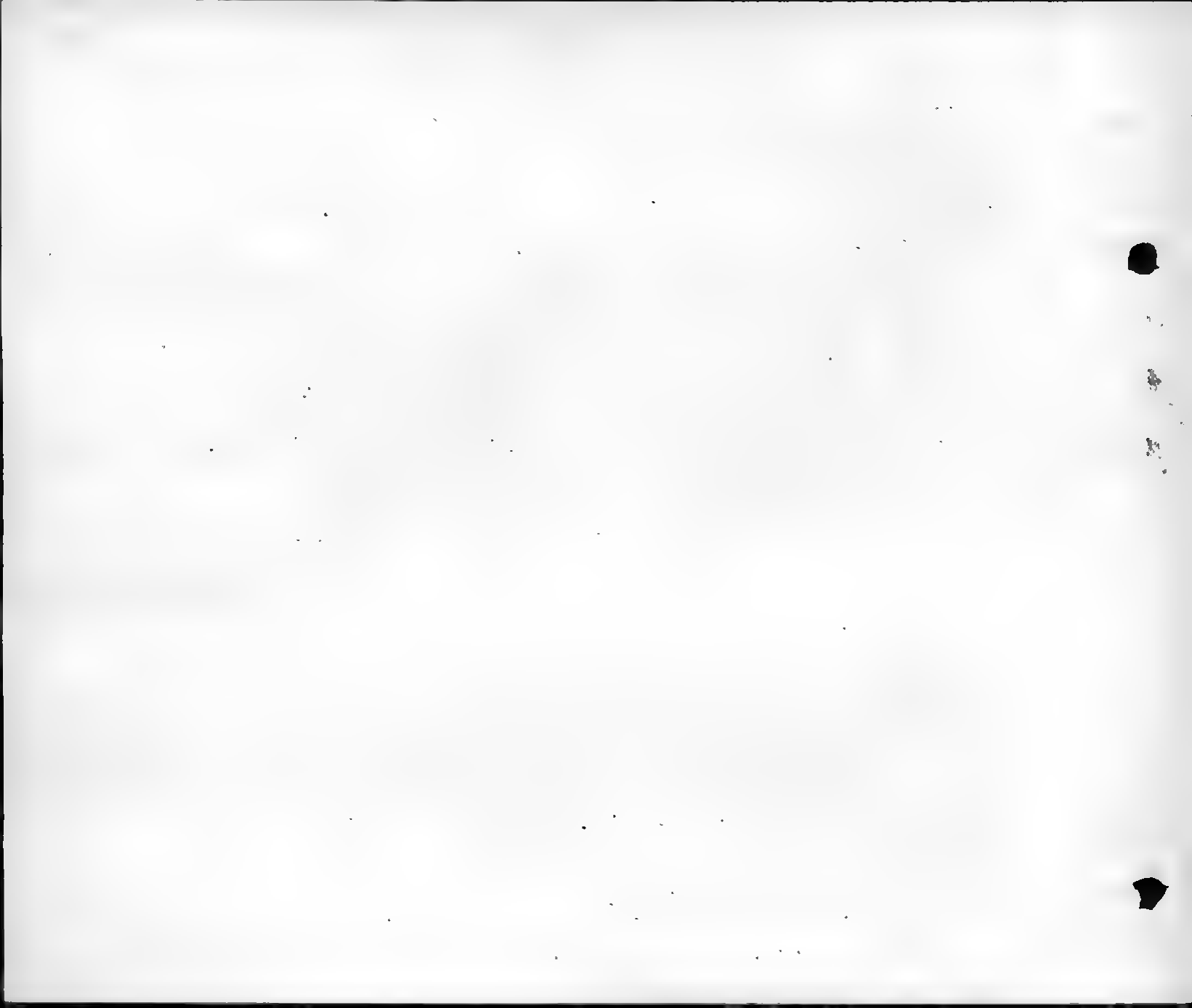
hours after death.

Page 4

The law requires that the death certificate be executed with

VS A15 (4)  
15M 9/58

retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 3634 CERTIFICATE OF DEATH

Reg. Dist. No.

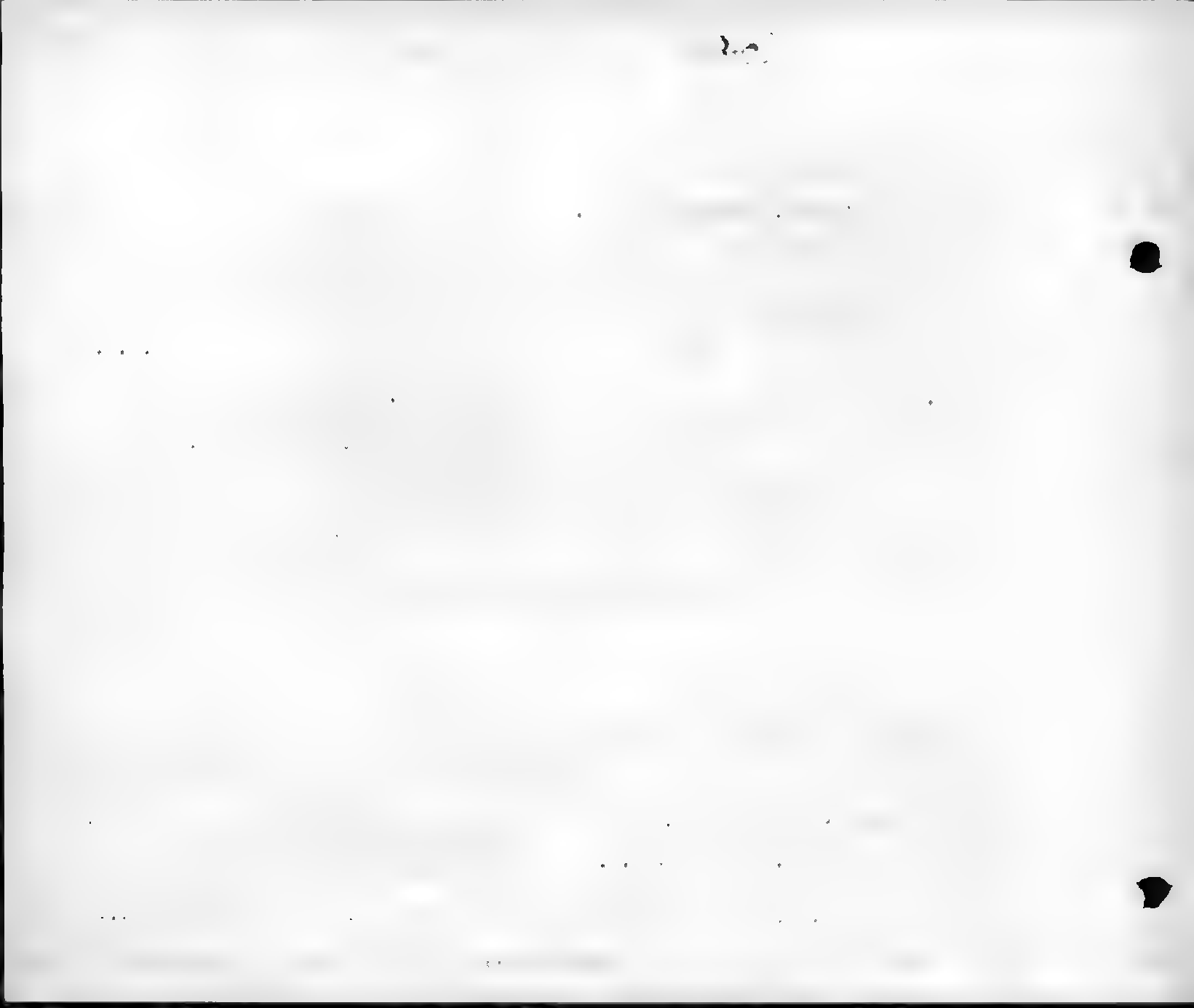
03575

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>52 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Eugene</b> Last <b>Shunk</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 14, 1914</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>18</b> Hours <b>19</b> Min <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Carl H. Shunk</b>				14. MOTHER'S MAIDEN NAME <b>Marcella E. Pearce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>None</b>			
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>196.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Massive metastasis to the left lung</b> DUE TO (c) <b>Metastatic osteogenic sarcoma</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>6 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 26, 1960</b> , to <b>March 18, 1960</b> , that I last saw the deceased alive on <b>March 18, 1960</b> , and that death occurred at <b>6:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/18/60</b>			
PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M.D.</b>				<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 21, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McConner Jr.</b>				ADDRESS <b>Abingdon, Md.,</b>		24a. REC'D BY REGISTRAR <b>MAR 23 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles L. Travis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH**  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4571 Dorset Ave</u>		d. STREET ADDRESS <u>4511 Dorset Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Emma Currie Skilling</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1870</u>
9. AGE (in years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Christian Currie</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Royer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John E. Skilling (son)</u>		Address <u>4500 Hunt St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cornary occlusion</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c): _____		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3. 30-60</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 7 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	





TO HEALTH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

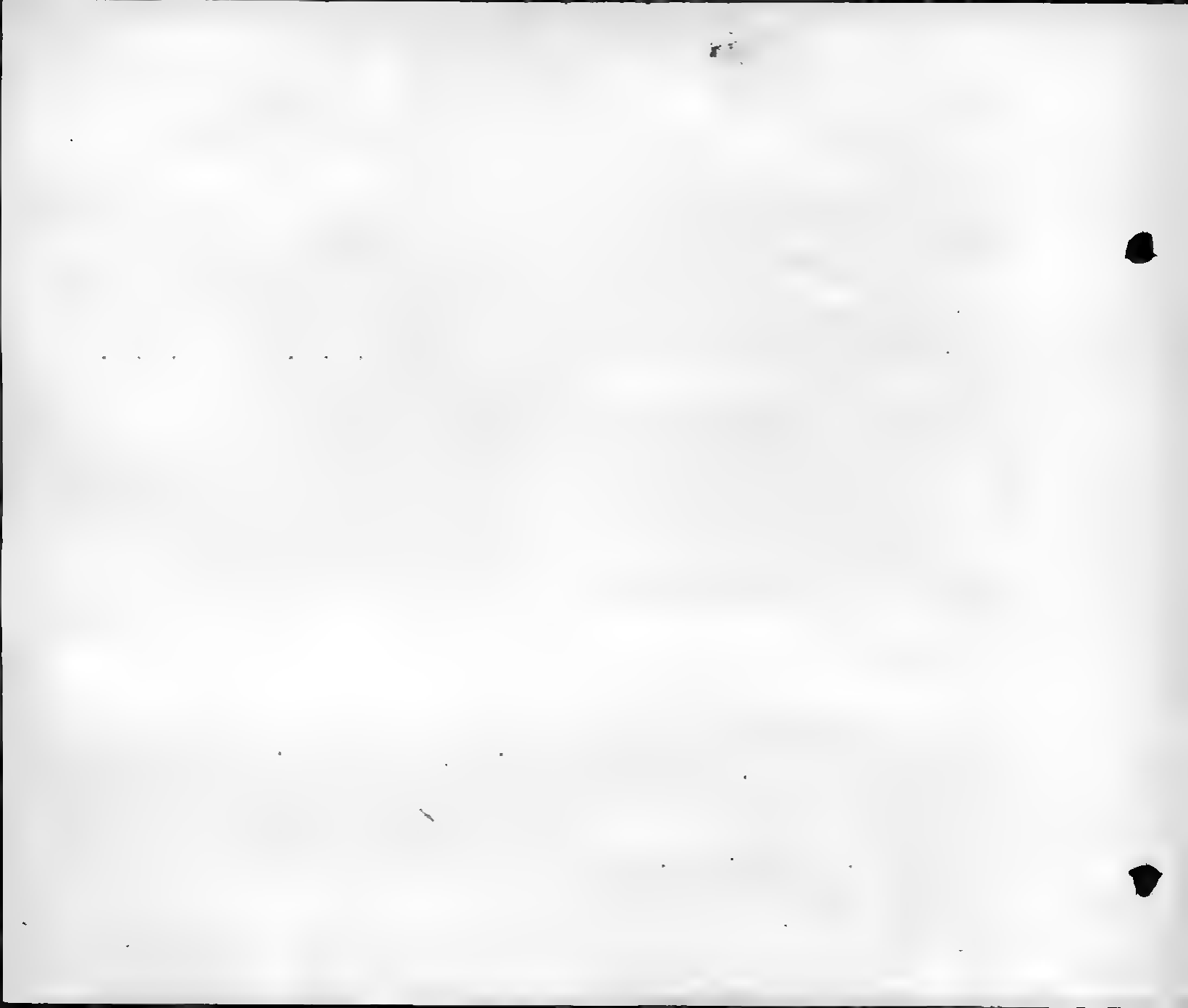
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3635

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Milton</u> Last <u>Simons</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/11</u>		9. AGE (in years last birthday) <u>48</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Allen John Simons</u>				14. MOTHER'S MAIDEN NAME <u>Delilah Boss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-05-0708</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Olney, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Primary carcinoma of the liver with metastases to hilar, abdominal and aortic lymph nodes</u> 155.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> 19 <u>59</u> to <u>Mar. 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Mar. 1</u> 19 <u>60</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>C. S. Whitaker,</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>				22d. ADDRESS <u>Clarksville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clarksville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McWitt Sandeldeen, Laurel, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Currier S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

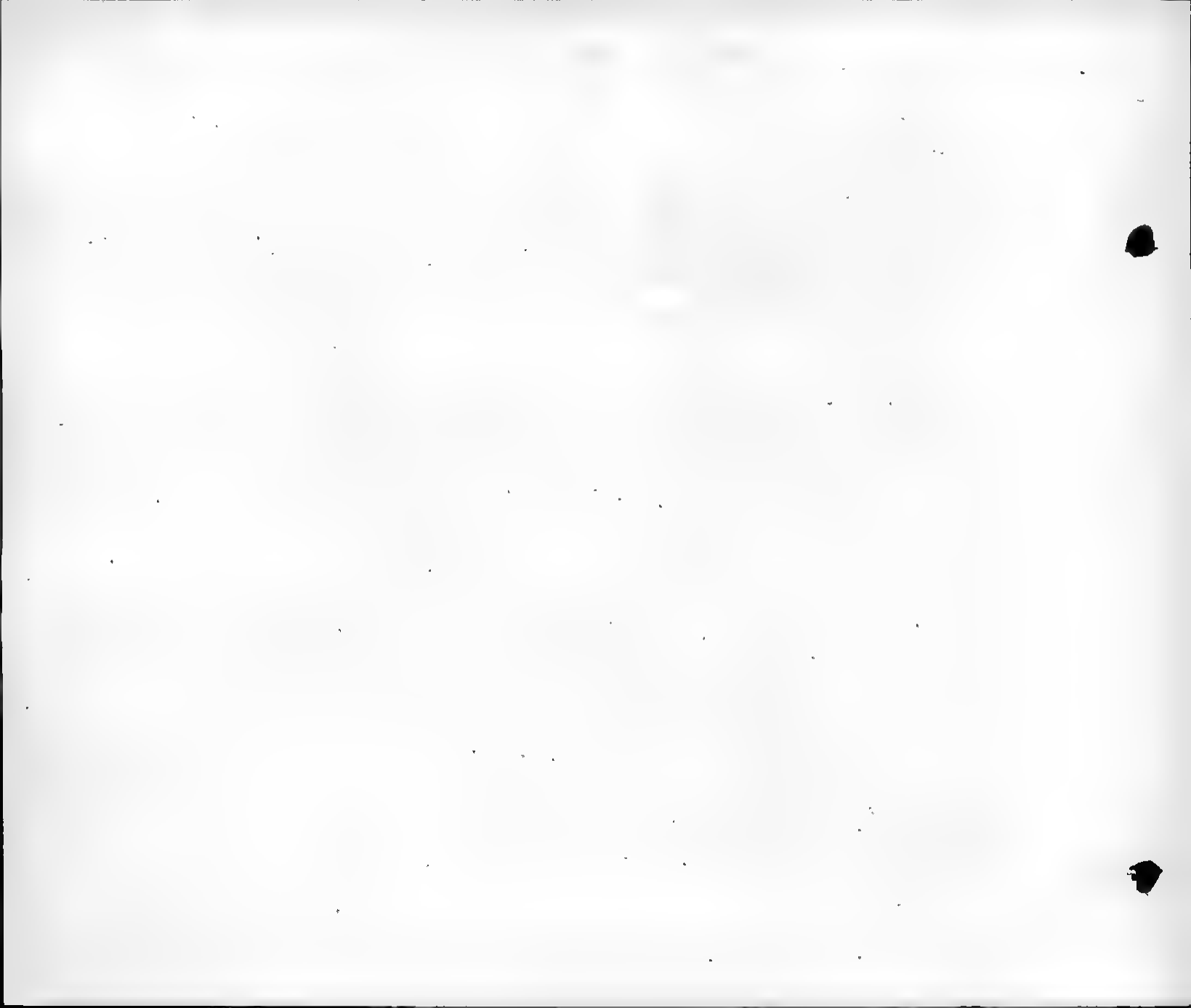
3636

CERTIFICATE OF DEATH

Reg. Dist. No.

03577

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>15508 McKinley St</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Sparks</u> Last <u>Sparks</u>		4. DATE OF DEATH <u>March 21, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/97</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bobek</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>James J. Sparks - Above</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Congestive Heart failure</u> (b) <u>Dilatation Right Ventricle</u> (c) <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Myeloma involving vertebral column, ribs &amp; left frontal lobe of brain</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1960</u> , to <u>March 21, 1960</u> , that I last saw the deceased alive on <u>March 21, 1960</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Humphrey, M.D.</u>		ADDRESS (Street, city or town, state) <u>1746 K St. N.W.</u> DATE SIGNED <u>3/21/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles W. Humphrey, M.D.</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>3/22/60</u>	<u>Cedar Hill Crematory</u>	<u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Humphrey</u>		24a. REC'D BY REGISTRAR <u>Charles S. Hume</u>	
ADDRESS <u>Bethesda, Maryland</u>		DATE <u>MAR 28 '60</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

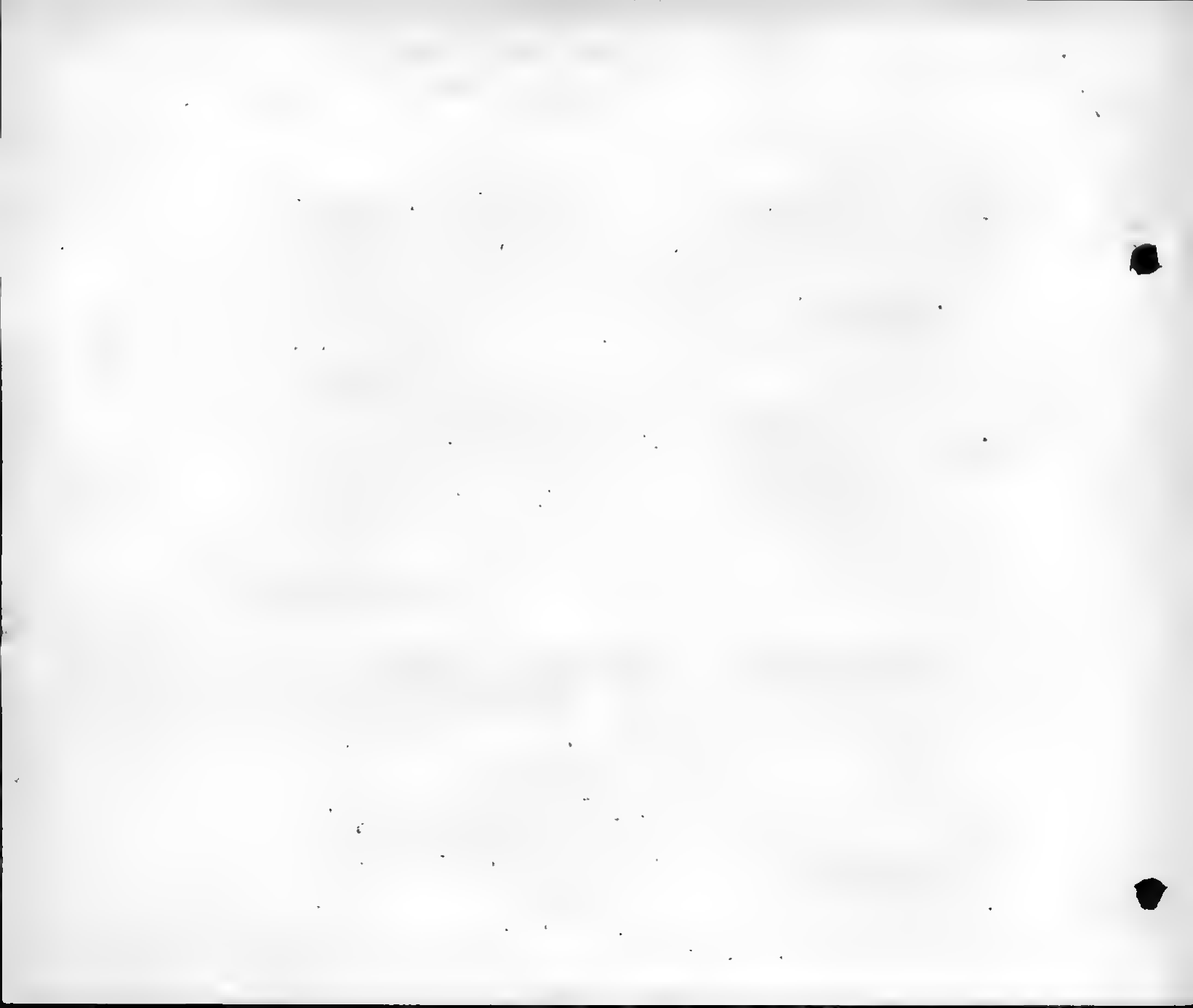
3515

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>26</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1918 Gainsboro Rd.</b>		d. STREET ADDRESS <b>1918 Gainsboro Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>ELIZABETH</b> Last <b>SPURRIER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1928</b>
9. AGE (In years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>14</b>	11. IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Aubrey Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Helen E. Birch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-34-8015</b>	
17. INFORMANT <b>Earl L. Spurrier-Item# 2</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>2-1X</b> <b>Hodgkin's Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Feb.</b> 1960 to <b>14 March</b> 1960 that I last saw the deceased alive on <b>13 March</b> 1960, and that death occurred at <b>2:12</b> A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W G Hall</b>		ADDRESS (Street, city or town, state) <b>615 W MONTGOMERY AVE ROCKVILLE, MD.</b>	
DATE SIGNED <b>3-14-60</b>			
PHYSICIAN'S NAME (Type) <b>W.G.Hall</b>		<b>615 W Montg. Ave., Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler-1331 E. Montg. Ave.</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 16 '60</b>		DATE <b></b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

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## 3638 CERTIFICATE OF DEATH

Reg. Dist. No.

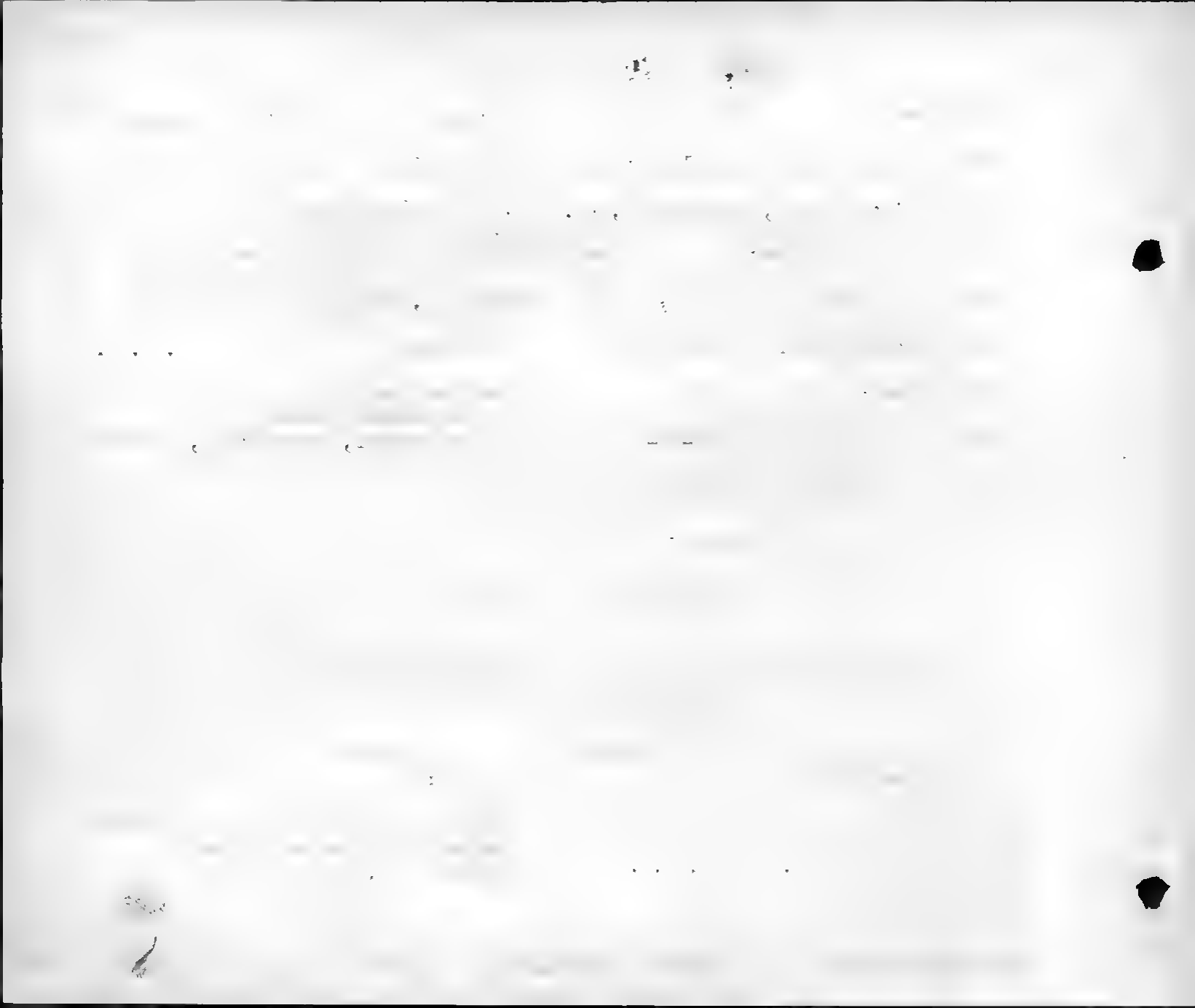
03580

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>			
c. LENGTH OF STAY IN 1b <b>152 days</b>				d. STREET ADDRESS <b>5820 Skyline Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cedric</b> Middle <b>Richard</b> Last <b>(KNUTH) Stahl</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 4, 1927</b>	
9. AGE (In years last birthday) <b>32</b> yrs		IF UNDER 1 YEAR Months <b>32</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>		IF UNDER 24 HRS Months <b>32</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aviation</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert Knuth</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Schulz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II 360-18-1898</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> DUE TO <b>204.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastro-intestinal hemorrhage</b> DUE TO (c) <b>Acute myelogenous leukemia</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b> <b>5 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 15, 1959</b> , to <b>March 15, 1960</b> , that I last saw the deceased alive on <b>March 15, 1960</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/15/60</b>							
ACTUAL SIGNATURE <b>Harold J. Fallon</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Harold J. Fallon, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>SIMPSON R.R.</b>		<b>3-16-1960</b>		<b>Chicago</b>		<b>Ill.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. ...</b>				ADDRESS <b>Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

1 hours after death. Page 4

TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



3490

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If instit. or Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>1500 Circle NW apt 417</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Heath San &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nettie May Stearns</u>		4. DATE OF DEATH <u>March 12 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 26 1913</u>
9. AGE (In years last birthday) <u>47</u> yrs		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Mins. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Nathaniel Eldridge</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Brackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>g't's chert &amp; daughter</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO (c) <u>Chronic Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-3</u> , 19 <u>60</u> , to <u>3-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Irey</u>		ADDRESS (Street, city or town, state) <u>7105 Riggs Rd. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		DATE SIGNED <u>3-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Mass.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. King Co 2401-14</u>		ADDRESS <u>at 2100</u>	
24a. REC'D BY REGISTRAR <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G258 3/11/60 1wk

3639

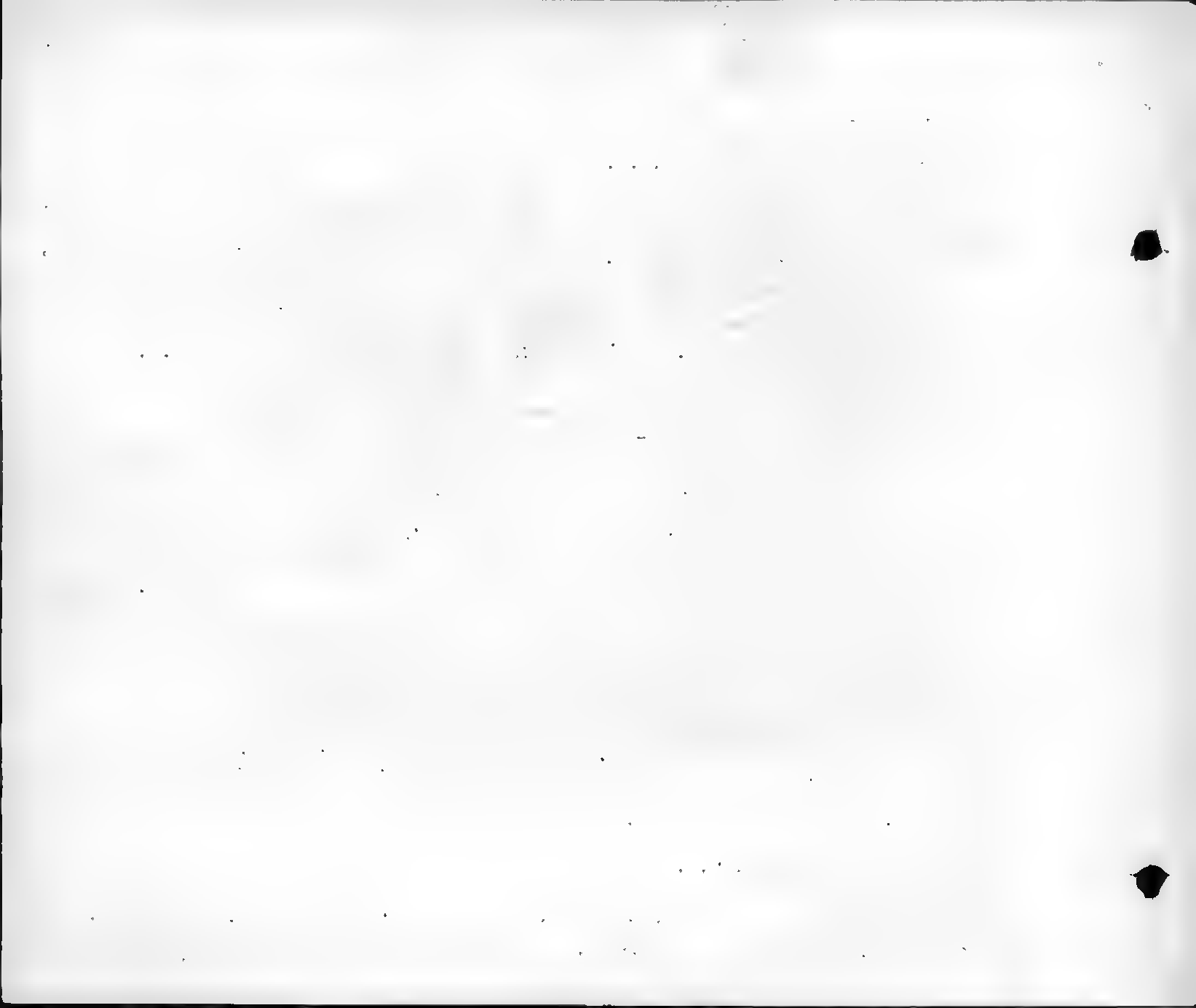
## CERTIFICATE OF DEATH

Reg. Dist. No.

03562

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>S.</u> Last <u>Steele</u>				4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/2/1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Magazine Publisher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Natl. Republic Mag.</u>			
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Steele</u>				14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-09-6115</u>			
17. INFORMANT <u>Wife -</u>				Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Temporary</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Rupture of Myocardium</u> (c) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Days</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/1/1958</u> to <u>3/2/1960</u> that I last saw the deceased alive on <u>3/2/1960</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>3/2/60</u>							
ACTUAL SIGNATURE <u>Stephen Jones, M.D.</u>				M.D. <u>Rockville, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Stephen Jones, M.D.</u>				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/5/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>MAR 7 '60</u>			
ADDRESS <u>Bethesda, Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

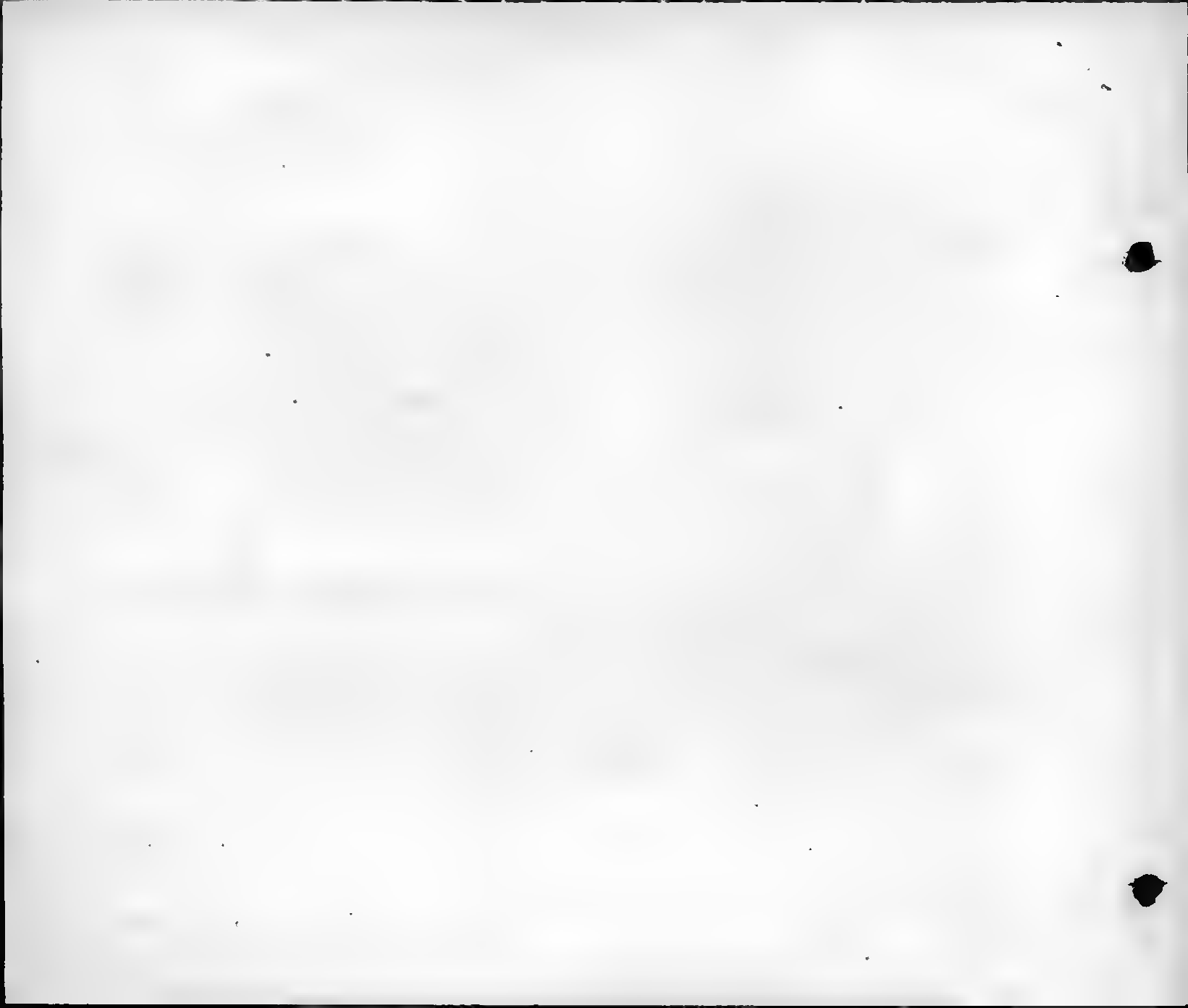
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**3491 CERTIFICATE OF DEATH**

03563

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home 8300 Baltimore Ave 1</u>				d. STREET ADDRESS <u>8500 16th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Elizabeth</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/81</u>	
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u>		11. IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Kent Island, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Pere S. Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Katherine E. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Rae Stewart 8500 16th Street Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (vascular)</u></p> <p><u>33IX</u> DUE TO <u>Arteriosclerosis</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Diabetes Mellitus</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>10 years</u> <u>3 years</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gangrene both lower extremities</u></p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 5, 1960</u> , to <u>March 4, 1960</u> that (I) (we) last saw the deceased alive on <u>March 4, 1960</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Max G. Sherer</u>				22b. DATE SIGNED <u>3/4/60</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>	
22d. ADDRESS <u>2025 EAST West H'way Sil. Sp. Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>MAR 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	





3502

## CERTIFICATE OF DEATH

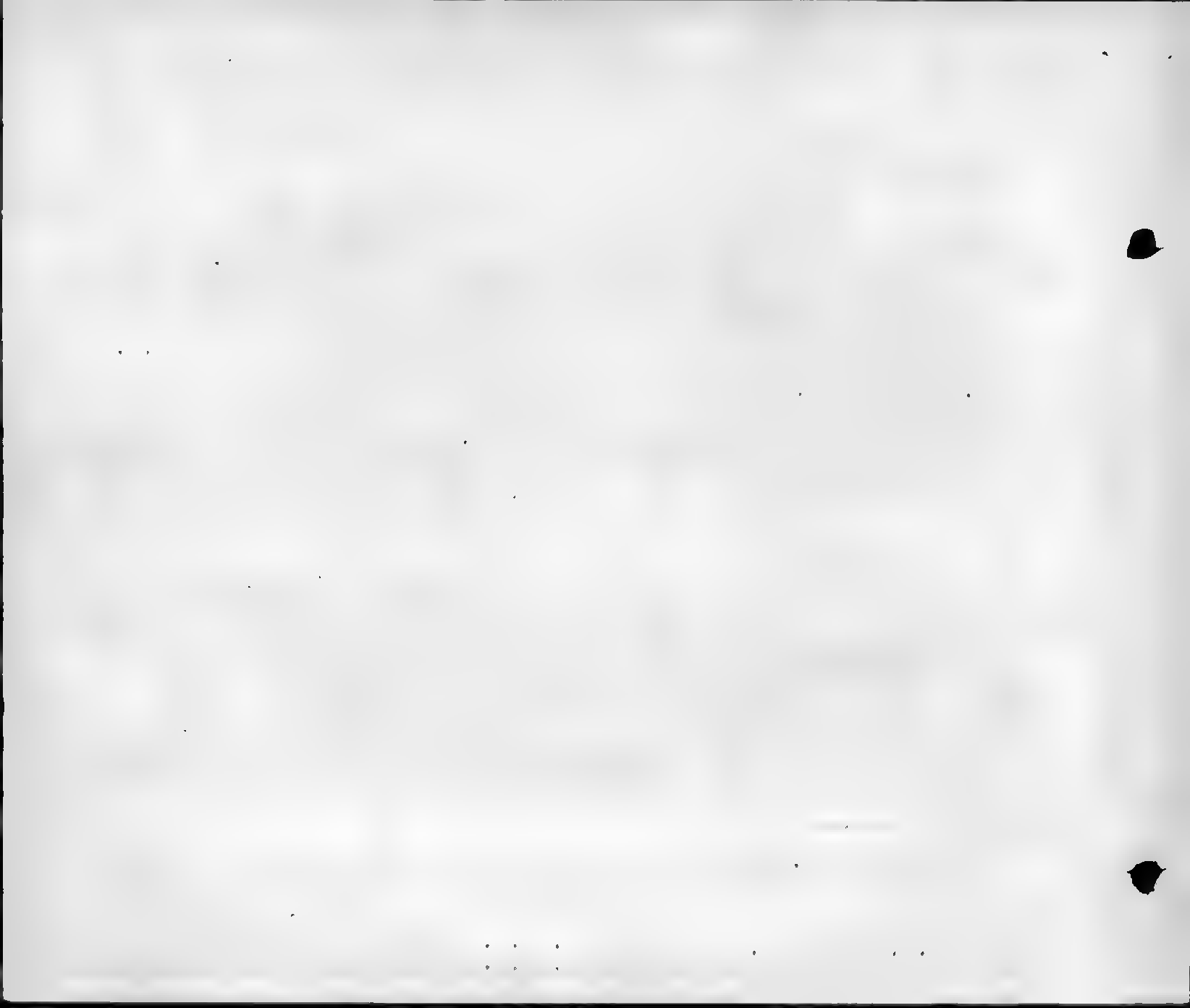
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3813 Williams Lane</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>3813 Williams Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lulah</b> Middle <b>Davidson</b> Last <b>Stout</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/81</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dr. Marshall M. Davidson</b>		14. MOTHER'S MAIDEN NAME <b>Roaine Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Jane E. Call</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal + Cardiac failure</b> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac-vascular-renal disease</b> DUE TO (c) <b>1 disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>25 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 19, 46</b> to <b>Mar. 7, 1960</b> , that I last saw the deceased alive on <b>Mar. 4, 1960</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7702 Camp Ave., Chevy Chase, Md.</b> DATE SIGNED <b>3-7-60</b>			
ACTUAL SIGNATURE <b>Philip H. Varner</b>		M.D. <b>Philip H. Varner</b>	
PHYSICIAN'S NAME (Type) <b>Philip H. Varner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>3/8/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Spring Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fauber, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR <b>MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

03585

3640

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Indiana</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>141 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Evansville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>816 East Mulberry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>O'Neal</b> Last <b>Strange</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1960</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 13, 1950</b>		9. AGE (In years last birthday) yrs. <b>10</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William W. Strange</b>				14. MOTHER'S MAIDEN NAME <b>Bessie J. Dilbeck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic Bronchopneumonia with Abscesses</b> DUE TO (b) <b>Hypoplastic Anemia (Fanconi) and Thrombocytopenia and Leukopenia</b> DUE TO (c) <b>Hypersteroidism (drug-induced)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 - 4 days</b> <b>3 years (congenital?)</b> <b>13 weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 9, 1959</b> , to <b>March 29, 1960</b> , that I last saw the deceased alive on <b>March 29, 1960</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Archie A. Mackinney Jr.</i>		M.D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>March 30, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Archie A. Mackinney, Jr., M.D.</b>		National Institutes of Health		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP RR.</b>		22b. DATE THEREOF <b>3-30-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Evansville Ind</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i>		ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>1400 Chapin St NW</b>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3641

## CERTIFICATE OF DEATH

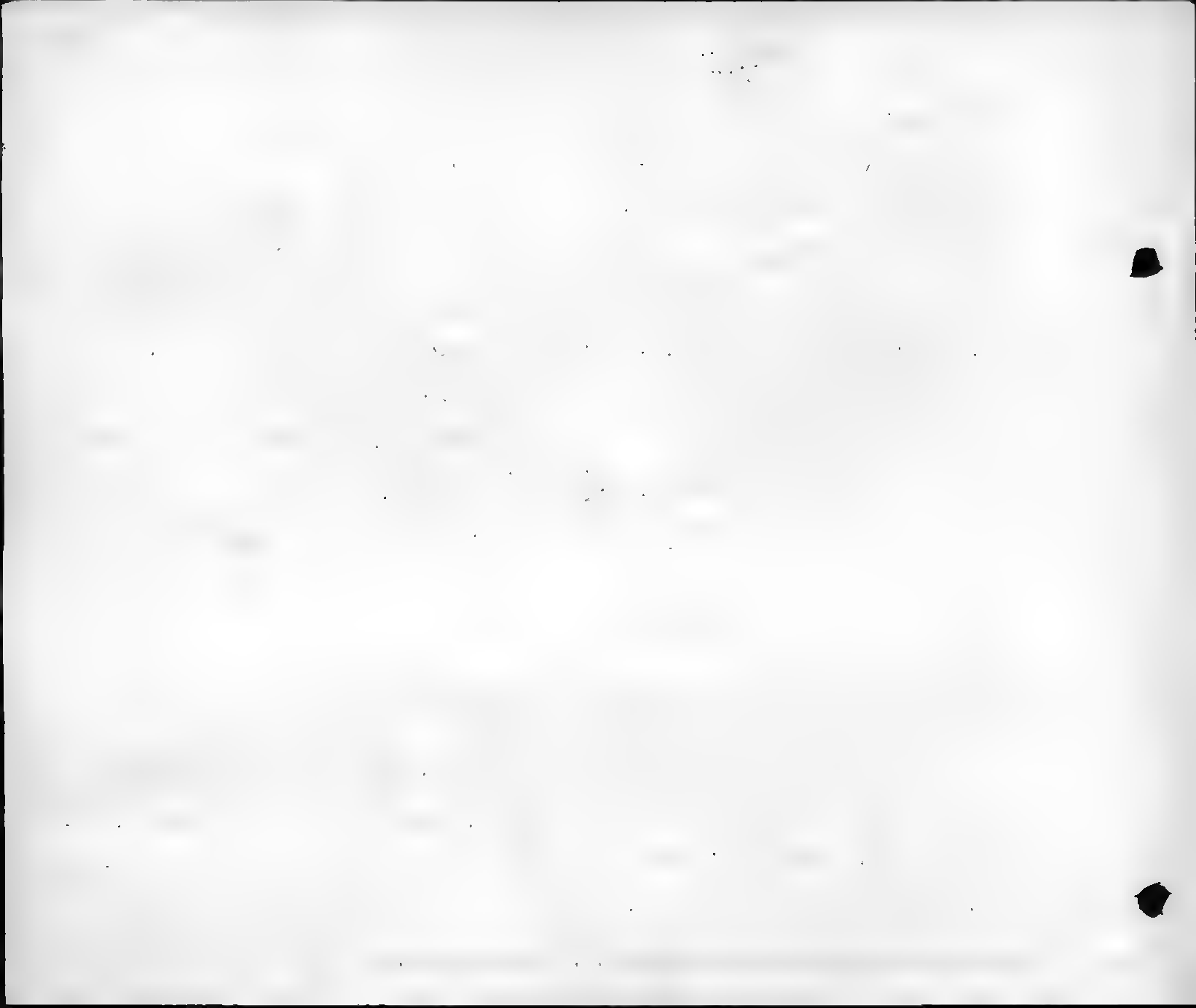
Reg. Dist. No. 215

03586

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>60 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Quantico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>82V 2</b> d. STREET ADDRESS <b>2766 "V"</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Louis STRATMANN</b>				4. DATE OF DEATH Month Day Year <b>March 20 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-2-19</b>	
9. AGE (In years last birthday) <b>40</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Louis (n) Stratmann</b>				14. MOTHER'S MAIDEN NAME <b>Minnie ELDERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>				16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>(Wife) Dorothy E. Stratmann</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Polycythemia Vera</b> <b>x 14 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral and pulmonary infection</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sub Total gastrectomy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 January</b> , 19 <b>60</b> , to <b>20 March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>20 March</b> , 19 <b>60</b> , and that death occurred at <b>10:58 PM</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 3-21-60</b>							
ACTUAL SIGNATURE <b>W.D. HOOVER</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W.D. HOOVER LT MC USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (See 15)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Shipment</b>		<b>3/22/60</b>		<b>Memorial Park</b>		<b>Vincennes Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				24a. REC'D BY REGISTRAR <b>DATE D. CMAR 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, within 72 hours after death.

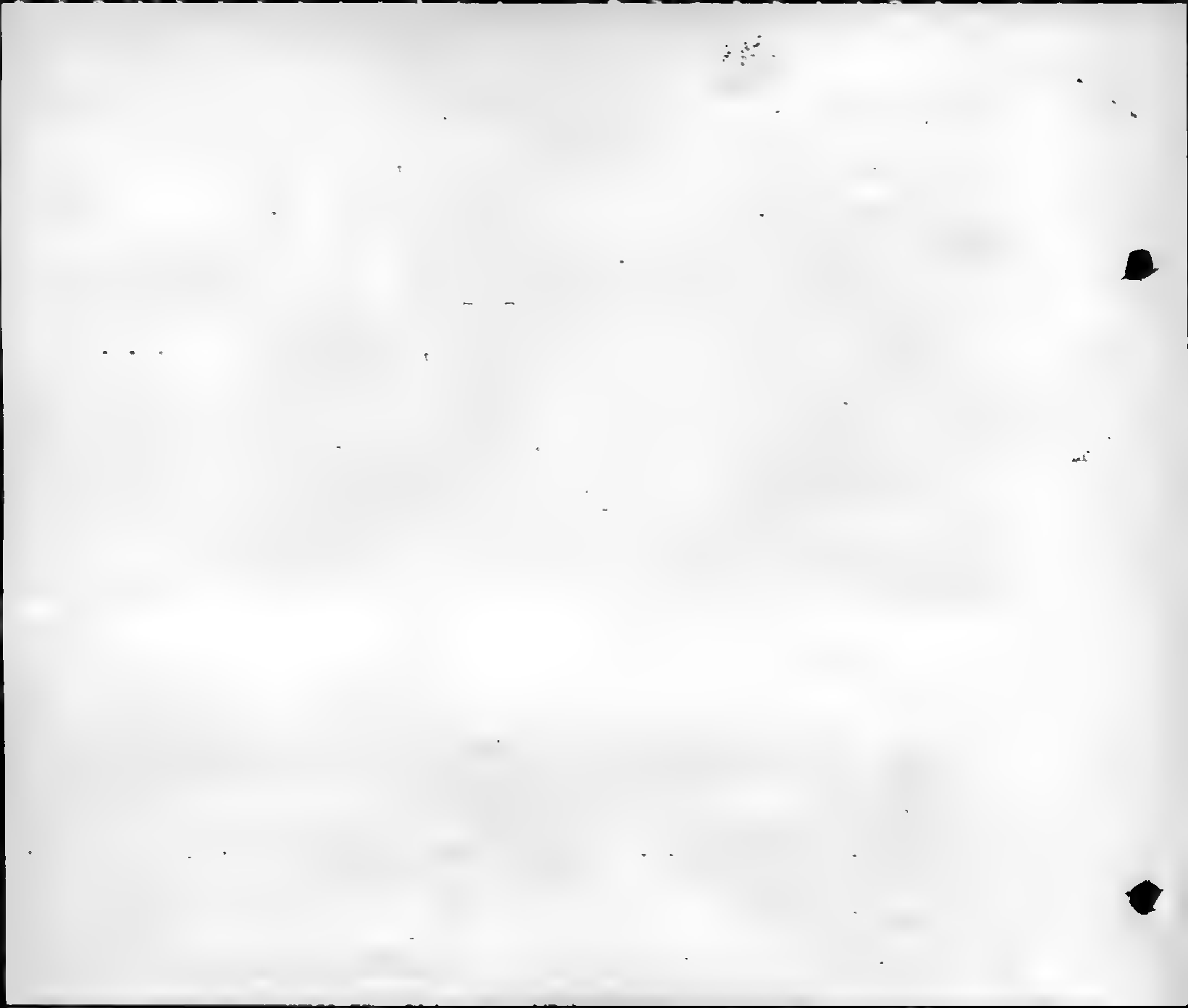
VR 11B (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03587

3642

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b> c. LENGTH OF STAY IN 1b <b>23 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b> d. STREET ADDRESS <b>4815 Edgefield Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Herbert M. Stroud</b>		4. DATE OF DEATH Month Day Year <b>March 15 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-1874</b>
9. AGE (In years last birthday) <b>85 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Ironia, New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel V. Stroud</b>	
14. MOTHER'S MAIDEN NAME <b>Josephine Latimore</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>W.A. Stroud - son - same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS A JPTPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/12 1960</b> to <b>3/15 1960</b> that (I) (we) last saw the deceased alive on <b>3/14 1960</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>W. T. Joyce</b> 22c. PHYSICIAN'S NAME (Type) <b>W. T. Joyce, M.D.</b>		22b. DATE SIGNED <b>3/15/60</b> 22d. ADDRESS <b>8106 Maple Ridge Rd. Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 3/16/60</b>		23b. DATE THEREOF <b>3/16/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Warren, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 17 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. L. Hume</b>			





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3643

## CERTIFICATE OF DEATH

Reg. Dist. No. 13568

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 days (11 Hrs)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. STREET ADDRESS <b>4408 Strathmore St.</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Sullivan</b> Last <b>Sullivan</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 60</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5/29/72</b>		9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>1</b> Min. <b>0</b>		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Joseph P White</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Bohama</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Granddaughter Mrs. Robt. Barclay</b>		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Perforated Gastric Ulcer</b> (c) <b>Chronic Gastric Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>History of Gastric Ulcer</b>		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>10609 Concord St. Kensington, Md</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>19</b> to <b>19</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>10609 Concord St. Kensington, Md</b>		DATE SIGNED <b>3/13/60</b>		ACTUAL SIGNATURE <b>Robert J. Thibadeau</b>		PHYSICIAN'S NAME (Type) <b>Robert J. Thibadeau</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Jeromes Cemetery</b>		22d. LOCATION (City, town, or county) <b>Schuylkill Co. Penna.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krouse</b>			

1

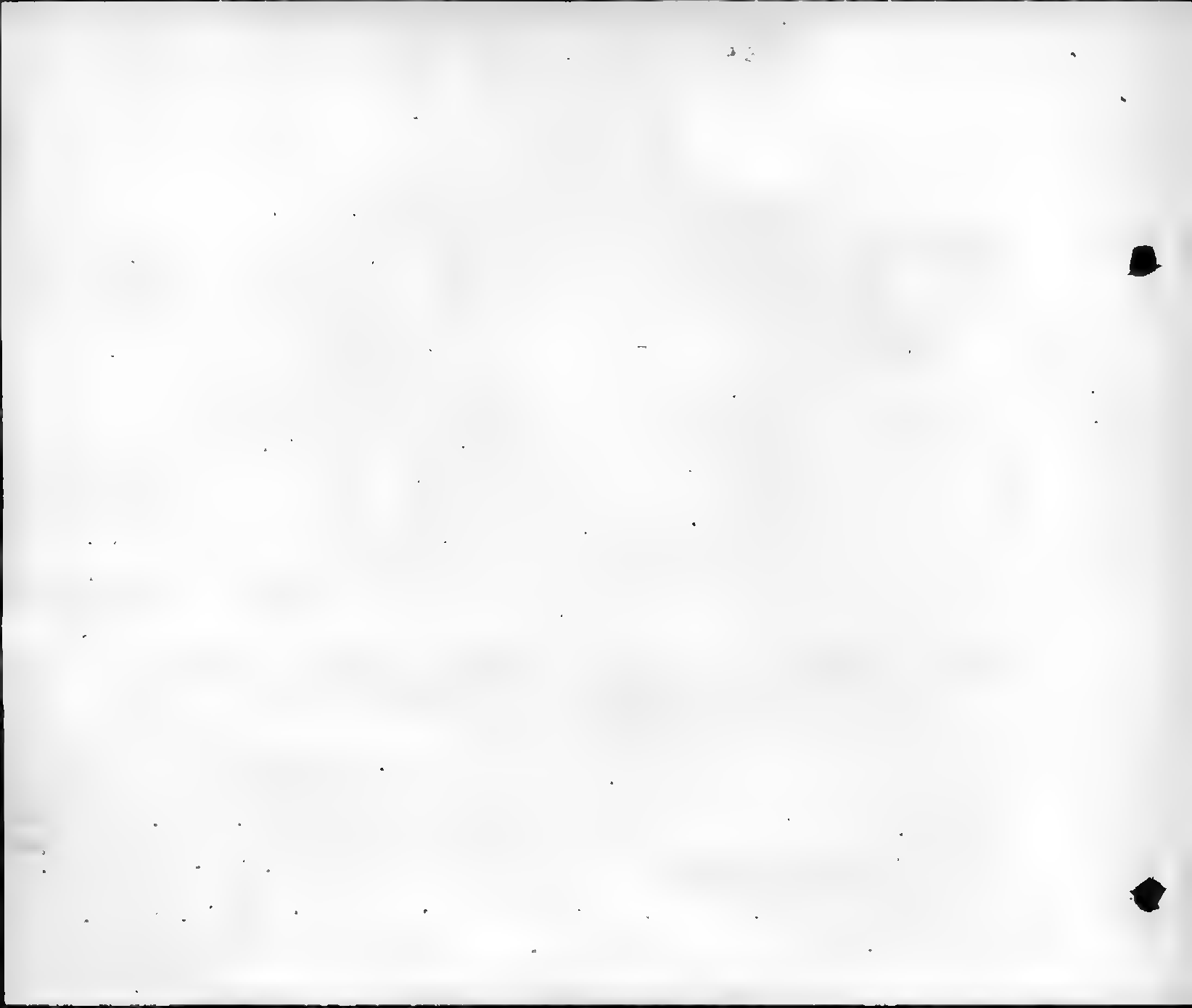
4 hours after death.

Page 4

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



3644

## CERTIFICATE OF DEATH

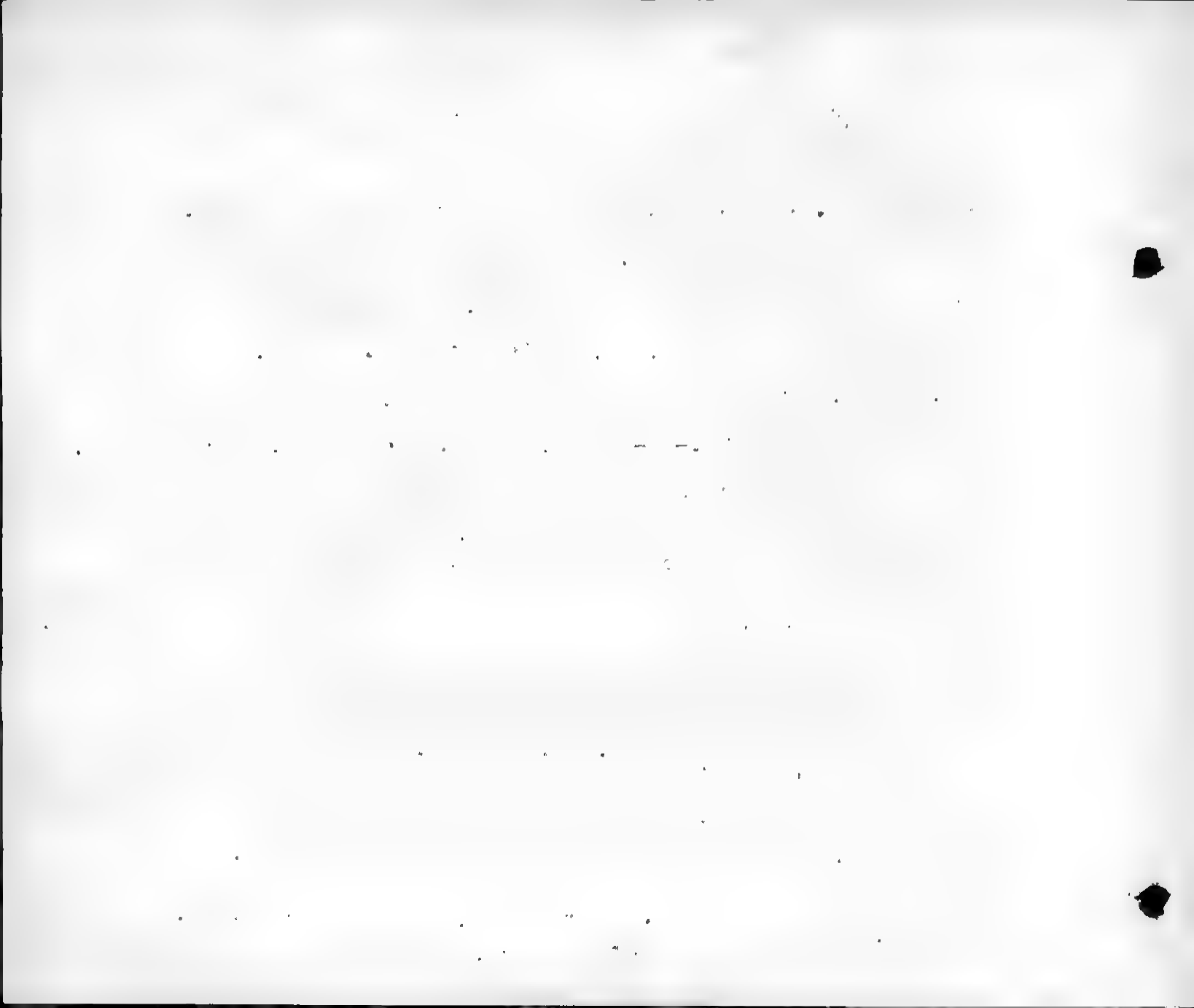
Reg. Dist. No.

03589

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>7 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. Gen. Hospital</b>				e. STREET ADDRESS <b>26745 Howard Chapel Dr.</b>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gwen</b> Middle <b>D.</b> Last <b>Tabler</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sep. 23, 1918</b>	
9. AGE (In years last birthday) <b>41</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>19</b> Min.		11. IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Montg. Co. Gov't nr Damascus, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank E. Duvall</b>				14. MOTHER'S MAIDEN NAME <b>Irene L. King</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-20-0354</b>			
17. INFORMANT <b>Albert S. Tabler, Jr.</b>				Address <b>Damascus, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Purpura Hemorrhagica</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Abdominal Carcinomatosis (Primary adenocarcinoma of the stomach)</b> (c) <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Furunculosis</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Damascus</b>				20g. (County) <b>Damascus</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan. 26, 1960</b> to <b>March 19, 1960</b> , that I last saw the deceased alive on <b>March 18, 1960</b> , and that death occurred at <b>4:10 a.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. McKendree Boyer</b>				ADDRESS (Street, city or town, state) <b>9830 Main Street</b>			
PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M. D.</b>				DATE SIGNED <b>3/19/60</b>			
22a. BURIAL, CREMATATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Moksunth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 22 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3492

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Damascus</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. Hosp.</i>		1. d. STREET ADDRESS <i>26812 Howard Chapel Dr.</i>	
3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>Byard</i> Last <i>Tabler</i>		4. DATE OF DEATH Month <i>March</i> Day <i>8</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs	IF UNDER 1 YEAR Months <i>74</i> Days <i>74</i> Hours <i>74</i> Min <i>74</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Levi A. Tabler</i>	
14. MOTHER'S MAIDEN NAME <i>Alveta Lewis</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-16-2111A</i>		INFORMANT <i>Pt's. Hospital Record</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Exsanguination, Shock</i> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Rupture Abdominal Aortic Aneurysm</i> DUE TO <i>Atherosclerosis Aorta &amp; Generalized</i> (c) <i>3 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-8</i> , 19 <i>60</i> , to <i>3-8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-8</i> , 19 <i>60</i> , and that death occurred at <i>8:05 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Marvin L. Kolkin</i> M.D.		ADDRESS (Street, city or town, state) <i>8485 Fenton Street, S.E., Md.</i>	
PHYSICIAN'S NAME (Type) <i>Marvin L. Kolkin</i>		DATE SIGNED <i>3/9/60</i>	
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF <i>3-11-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Kempton</i>	22d. LOCATION (City, town, or county) (State) <i>Kempton, Mont. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber - Laytonville, Md.</i>		ADDRESS <i>Laytonville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1

TE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



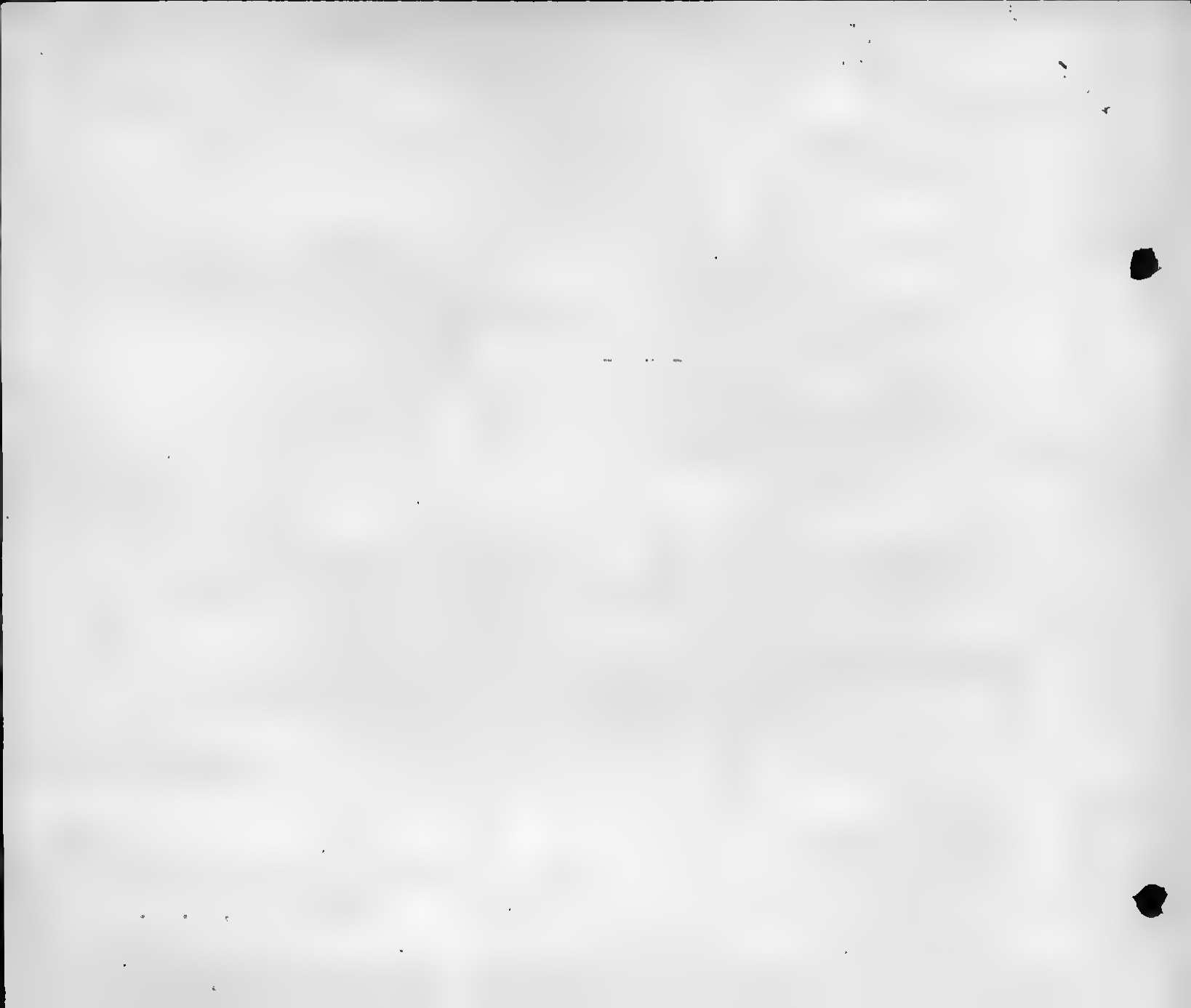
16  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health; or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03591											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>20 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>55-23 Southview St</u>						e. STREET ADDRESS <u>55-23 Southview St</u>					
3. NAME OF DECEASED (Type or print) <u>Alma Estelle Talbert</u>						4. DATE OF DEATH <u>mar 18 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR <u>8</u> Months <u>28</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						11. BIRTHPLACE (State or foreign country) <u>DC</u>					
13. FATHER'S NAME <u>Francis Tucker</u>						14. MOTHER'S MAIDEN NAME <u>Ella Pasay</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>					
17. INFORMANT <u>Ellen Wensler (daughter)</u>						Address <u>9427 Markham St Silver Spring, md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>						20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>						20f. (City or town) <u></u> (County) <u></u> (State) <u></u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broseant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. BROSEANT</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>3/21/60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>						22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>						24a. REC'D BY REGISTRAR <u>MAR 22 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Carling S. Thomas</u>					





TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03592

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7701 Chelton Drive Road</b>		d. STREET ADDRESS <b>7701 Chelton Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Stafford TAYLOR</b>		4. DATE OF DEATH Month Day Year <b>Mar. 27, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1907</b>
9. AGE (In years last b. rthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>52</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Stephen Stafford</b>		14. MOTHER'S MAIDEN NAME <b>Mattie G. Perrie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Husband</b> <b>Charles Taylor</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>Mar. 27, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 30 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	



3647  
CERTIFICATE OF DEATH

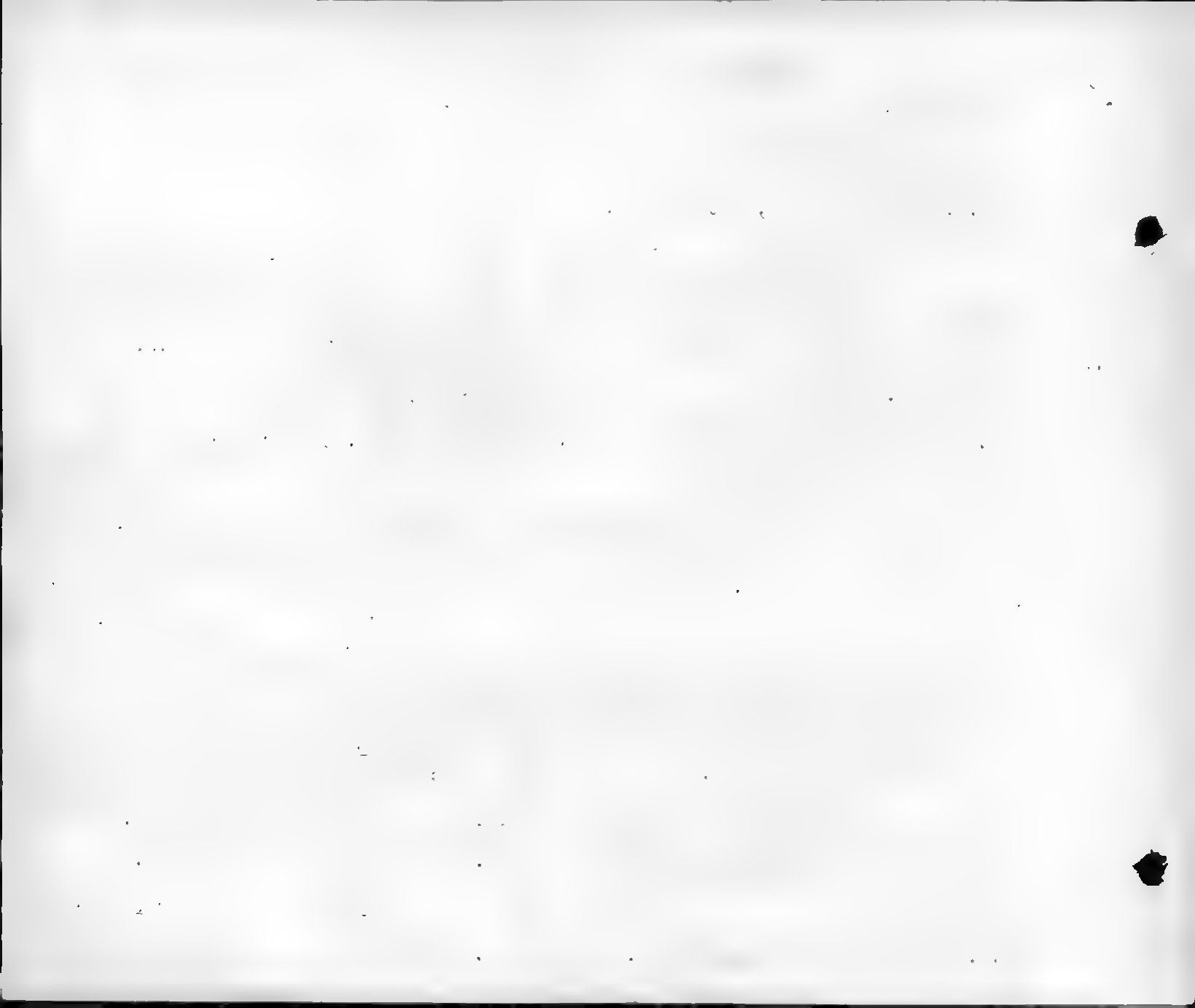
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN Tb <b>3 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lancaster</b> d. STREET ADDRESS <b>Woodland Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Elizabeth</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-24-59</b>
9. AGE (In years last birthday) <b>2</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>14</b>	11. IF UNDER 24 HRS Hours <b>14</b> Min <b>14</b>
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles W. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Laura REEVES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>(Father) Charles W. Taylor</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anoxia-</b> <b>525X</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Interstital pneumonia involving both lungs - total hepaticization</b> (c) <b>pneumocystis carinii or Hamman-Rich</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <b>Severe pulmonary hypertension with right ventricular hypertrophy and strain</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>10 days</b> <b>2 wks</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 March 1960</b> to <b>9 March 1960</b> , that I last saw the deceased alive on <b>9 March 1960</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>3-10-60</b>			
ACTUAL SIGNATURE <b>G.B. Avery</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>G.B. AVERY LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>SHIPMENT 3-10-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Lancaster South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	
ADDRESS <b>1557 Wisconsin Ave. Bethesda Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

900000 VUX00



3648

## CERTIFICATE OF DEATH

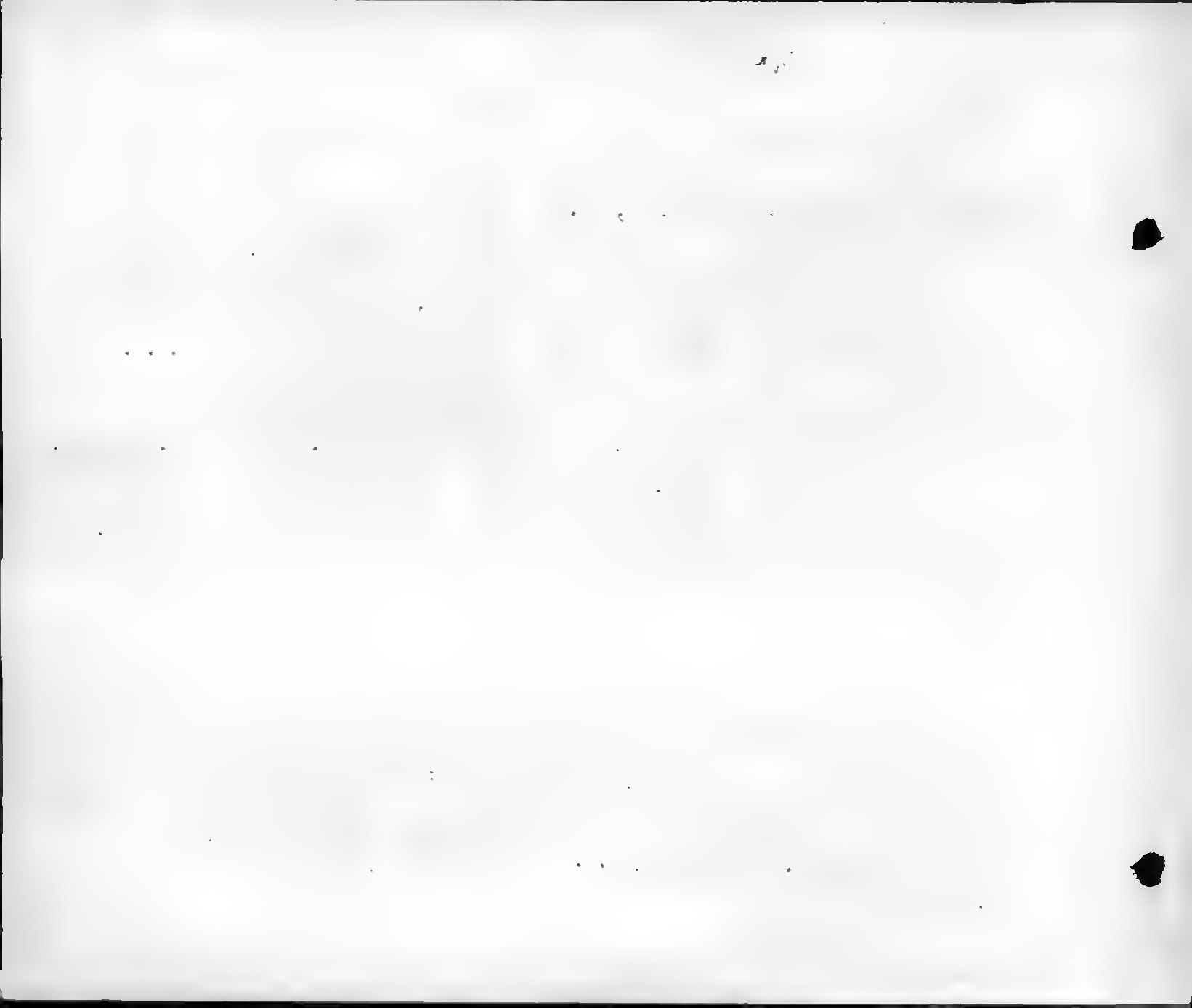
03594

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY N 1b <b>22 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Seneca</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seneca</b> d. STREET ADDRESS <b>Route # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Davis Taylor</b>		4. DATE OF DEATH Month Day Year <b>March 26 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1923</b>
9. AGE (In years last birthday) <b>36 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Parts Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Davis Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Carpenter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>193.0</b> DUE TO <b>Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral glioma</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 4</b> , 19 <b>60</b> , to <b>March 26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 26</b> , 19 <b>60</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/26/60</b> NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <i>Joseph J. Adamkiewicz</i>		PHYSICIAN'S NAME (Type) <b>Joseph J. Adamkiewicz, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>STATE RR</b>		22b. DATE THEREOF <b>3-27-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>W.W. Chambers</b>		22d. LOCATION (City, town, or county) (State) <b>SENECA S.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i>		24a. REC'D BY REGISTRAR DATE <b>MAR 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <i>Carlton S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3492

## CERTIFICATE OF DEATH

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If that in hospital give street address) OR INSTITUTION <u>Wash. San. Hospital</u>				d. STREET ADDRESS <u>9320 Ocata St.</u>			
3. NAME OF DECEASED (Type or print) <u>Harry Clinton Thompson</u> First Middle Last				4. DATE OF DEATH <u>March 2</u> Month Day Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-96</u>	9. AGE (in years lost birthday) <u>62</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt. Special Police</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Nary J. Appel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>army</u>				16. SOCIAL SECURITY NO. <u>none</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized adenocarcinomatosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>18 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 29, 1960</u> to <u>Mar. 2, 1960</u> , that I last saw the deceased alive on <u>Mar. 1, 1960</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Paul V. Starr</u>				ADDRESS (Street, city or town, state) <u>7600 Larwood Ave. Mar. 2-60</u>			
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>				DATE SIGNED <u>Mar. 2-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

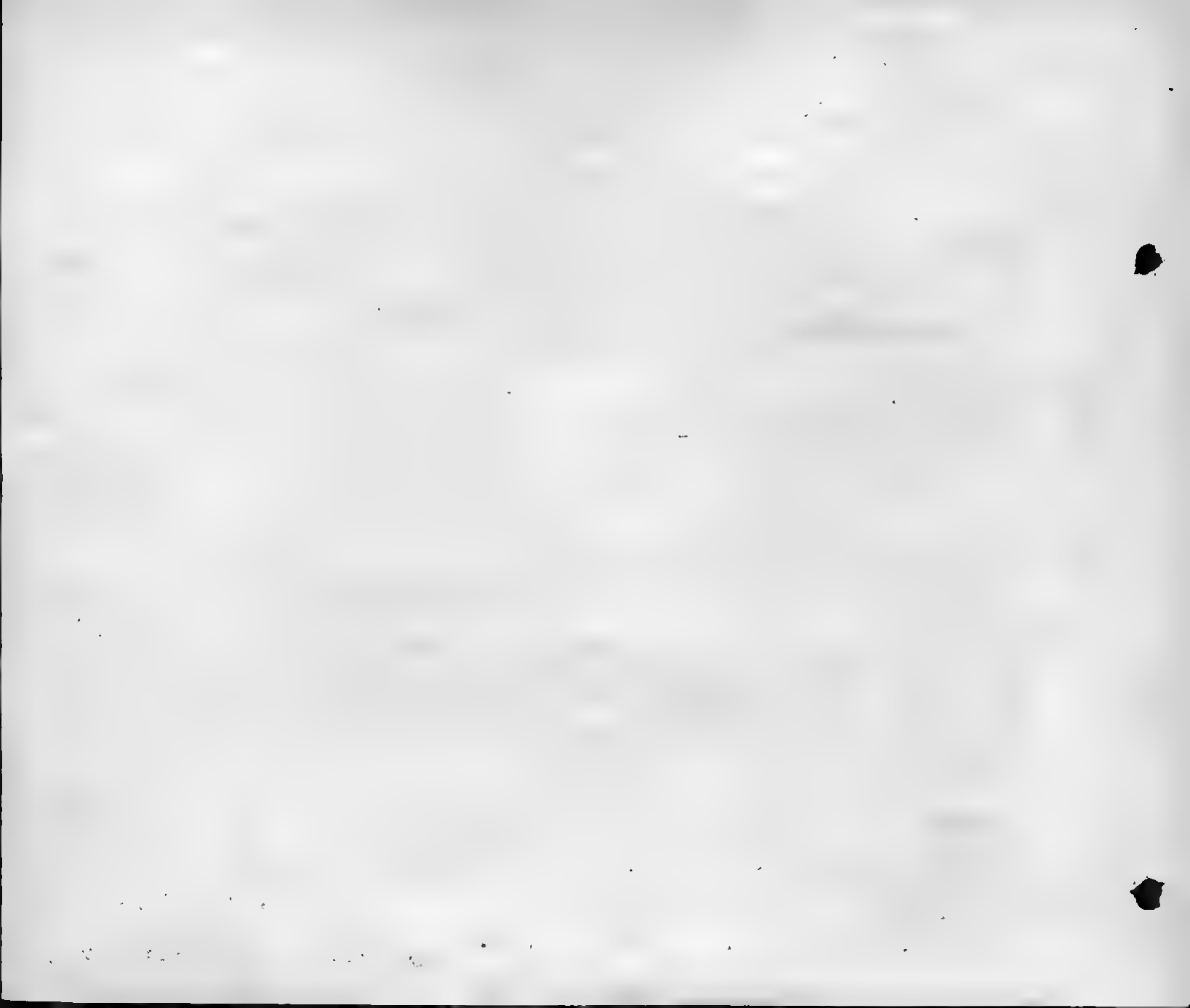
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





VE. A15ME  
5M 7/59

1. PLACE OF BIRTH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11026 Burnley Ter</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11026 Burnley Ter</u>	
3. NAME OF DECEASED (Type or print) <u>Octavia Gilbert Thornton</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-3-1918</u> 9. AGE (In years last birthday) <u>41</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done and hours and days worked) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Handley Ford Dealer</u> 11. BIRTHPLACE (State or foreign country) <u>S.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>14</u> Year <u>1960</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Mathew H. Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Josie Olsen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>247-01-0068</u>	
17. INFORMANT <u>Dorothy Thornton - Sister</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>775.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. SIGNATURE <u>Frank J. Brosch</u> M.D.		22b. DATE THEREOF <u>3-15-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Greenville, South Carolina</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> <u>Emmanuel S. Brosch</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	



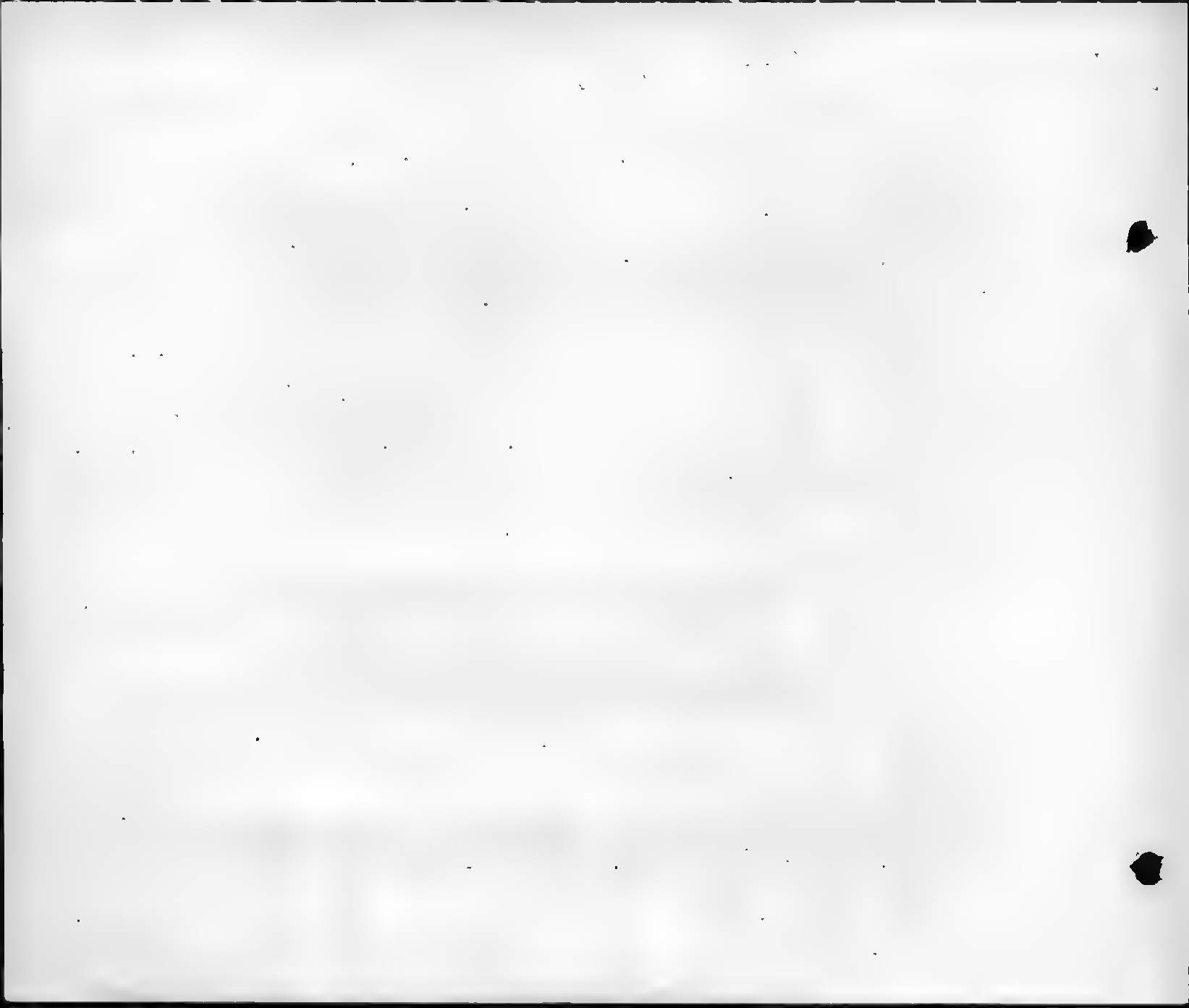
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3649

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03597

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8604 Grant St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Bethesda,</b>	
3. NAME OF DECEASED (Type or print) <b>MRS-Jessie</b> First <b>D.</b> Middle <b>Tidwell.</b> Last		4. DATE OF DEATH <b>March</b> Month <b>12</b> Day <b>1960.</b> Year	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 5, 1897</b>
9 AGE (in years last birthday) <b>63</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Hugh Calvin Douglas</b>		14. MOTHER'S MAIDEN NAME <b>Carrie B. Coleman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16 SOCIAL SECURITY NO <b>465-18-9000</b>	
17 INFORMANT <b>Sister</b>		Address <b>8604 Grant St. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>170X</b> DUE TO (b) <b>Metastatic Carcinoma of breast.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 20, 1960</b> to <b>Mar. 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>Mar. 12, 1960</b> , and that death occurred on <b>Mar. 12, 1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George A. Gray, Jr.</b>		22b. DATE SIGNED <b>3/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George A. GRAY, JR. M.D.</b>		22d. ADDRESS <b>4422 East West Highway, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 15, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Maryland</b>	
25a. REC'D BY REGISTRAR <b>MAR 16 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13598

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>11111111111111111111</u>	
3. NAME OF DECEASED (Type or print) First <u>Floyd W.</u> Middle <u>TILLEY</u> Last <u>TILLEY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT TILLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PIGG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>AUBREY TILLEY</u>	
17. INFORMANT <u>Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of tongue with metastases</u> DUE TO (b) <u>141.0</u> DUE TO (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>141.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> <u>1960</u> , to <u>3/7</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> <u>1960</u> , and that death occurred at <u>2:00 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. H. HIGDON</u>		22b. DATE SIGNED <u>3/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. HIGDON</u>		22d. ADDRESS <u>Sandy Spring, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 10 '60</u>	
ADDRESS <u>300-4th St. N.E.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thayer</u>	



3494  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution-Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>5 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 TAKOMA PARK</i>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>705 1/2 Chesapeake Avenue</i>				d. STREET ADDRESS <i>8461 BARRON ST</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MINNIE ALICE TOLSON</i>				4. DATE OF DEATH Month <i>March</i> Day <i>11</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JUNE 13, 1873</i>	
9. AGE (In years last birthday) <i>86 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTH PLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTH PLACE (State or foreign country) <i>Washington, D.C.</i>	
13. FATHER'S NAME <i>Not Available</i>				14. MOTHER'S MAIDEN NAME <i>Not Available</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Luen McCarthy (same as #2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>4 to 0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senile Arteriosclerosis</i> DUE TO (c) <i>10 years</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3 May</i> , 1953, to <i>11 Mar.</i> , 1960, that I last saw the deceased alive on <i>9 March</i> , 1960, and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>H.B. Queen</i>				ADDRESS (Street, city or town, state) <i>MD 7112 Willow Ave 11 Mar 1960</i>			
PHYSICIAN'S NAME (Type) <i>H.B. QUEEN</i>				TAKOMA PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 14, 1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick, Sh. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW DC</i>				24a. REC'D BY REGISTRAR <i>MAR 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

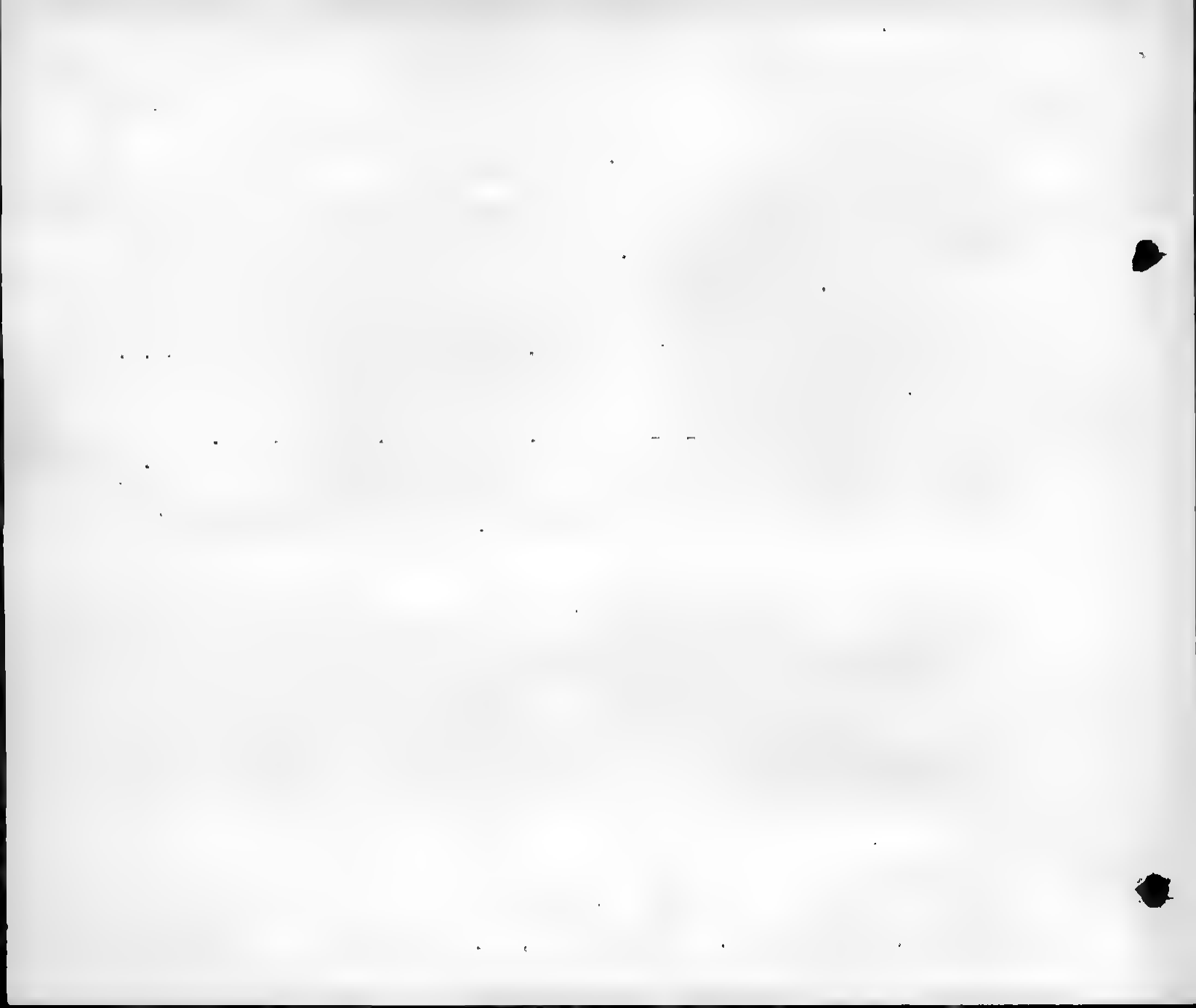
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15M 9/59

3454

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03600

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 HILLTOP ROAD		d. STREET ADDRESS 1 7 HILLTOP ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SIDNEY A. TRUNDLE		4. DATE OF DEATH Month Day Year March 22 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Clerk		10b. KIND OF BUSINESS OR INDUSTRY G&P Telephone Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAYTON TRUNDLE		14. MOTHER'S MAIDEN NAME EMMA SAPPINGTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 577-01-0922	
17. INFORMANT Mrs. Katherine B. Trundle, 7 Hilltop Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses, Multiple DUE TO (b) Cerebro sclerosis, chronic. Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia with emphysema, chronic Chronic Coronary Arterio-sclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1958, to Mar 22, 1960, that (I) (we) last saw the deceased alive on Mar 22, 1960, and that death occurred at 9:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George L. Ball		22b. DATE Mar 22, 1960	
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 1520 Georgia Ave Silver Spring, Md	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/25/60	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. F. FINE, INC. Raymond H. Fiska		25a. RECEIVED BY REGISTRAR DATE MAR 28 60	
25b. REGISTRAR'S SIGNATURE C. L. Fiska			



3650

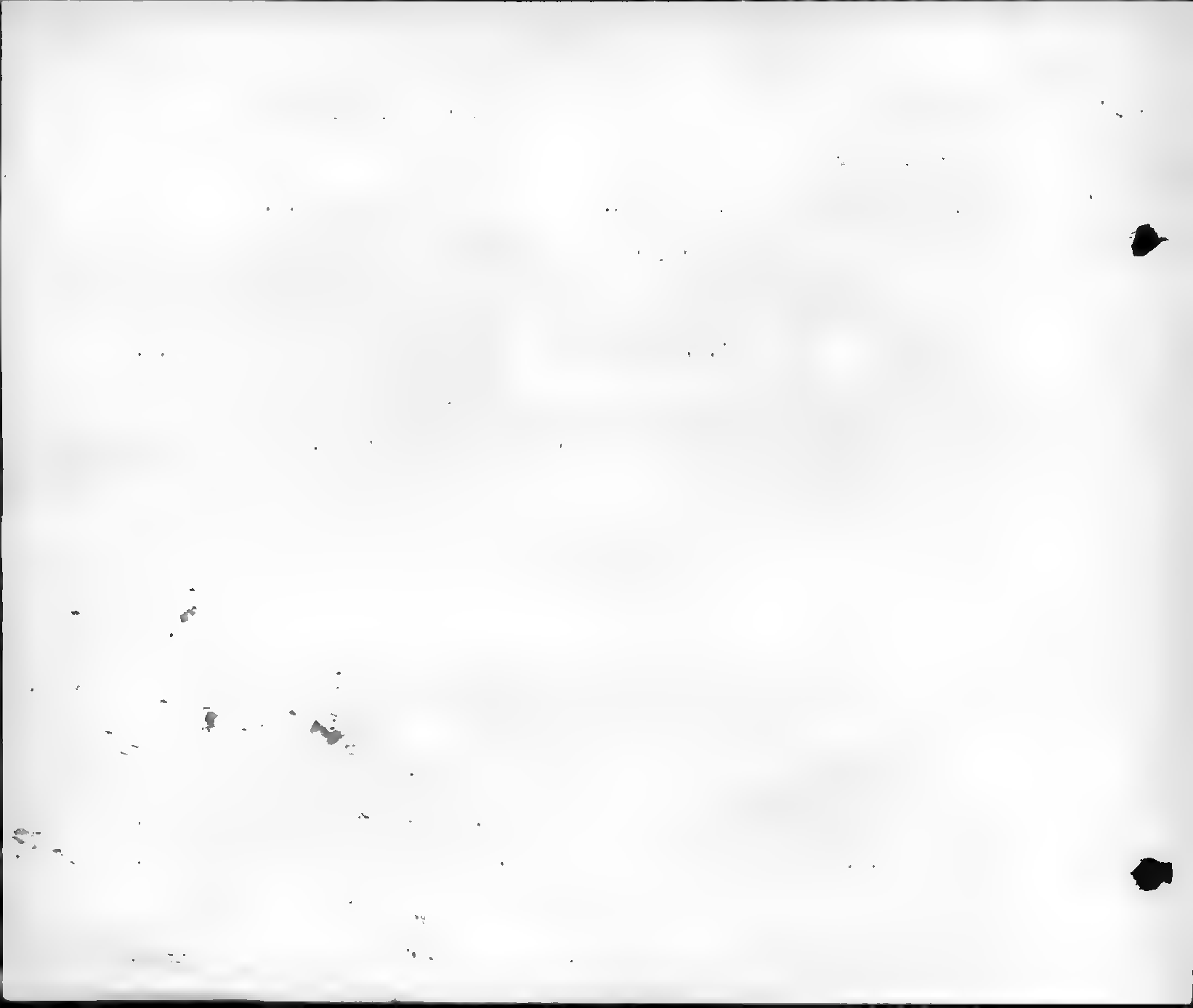
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>34 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1723 34th Street N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Frederick TUCKER</b>		4. DATE OF DEATH Month Day Year <b>March 12 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-80</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frederick A. TUCKER</b>		14. MOTHER'S MAIDEN NAME <b>Nora REARDON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I &amp; II 577 42 2577</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic Heart Disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Lower Lobe Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>many years</b> <b>many years</b>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>21:05A</b>	
20c. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Hospital, Bethesda Md.</b>	
20e. (City or town) <b>Bethesda</b>		20f. (County) (State) <b>Montgomery Maryland</b>	
21. I certify that I attended the deceased from <b>7 February</b> , 19 <b>60</b> , to <b>12 March</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12 March</b> , 19 <b>60</b> , and that death occurred at <b>21:05A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Davis</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md. 3-14-60</b>	
PHYSICIAN'S NAME (Type) <b>J.W. DAVIS LT MC USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Devol</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 15 '60</b>	
ADDRESS <b>2224 Wisconsin Ave. Bethesda Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

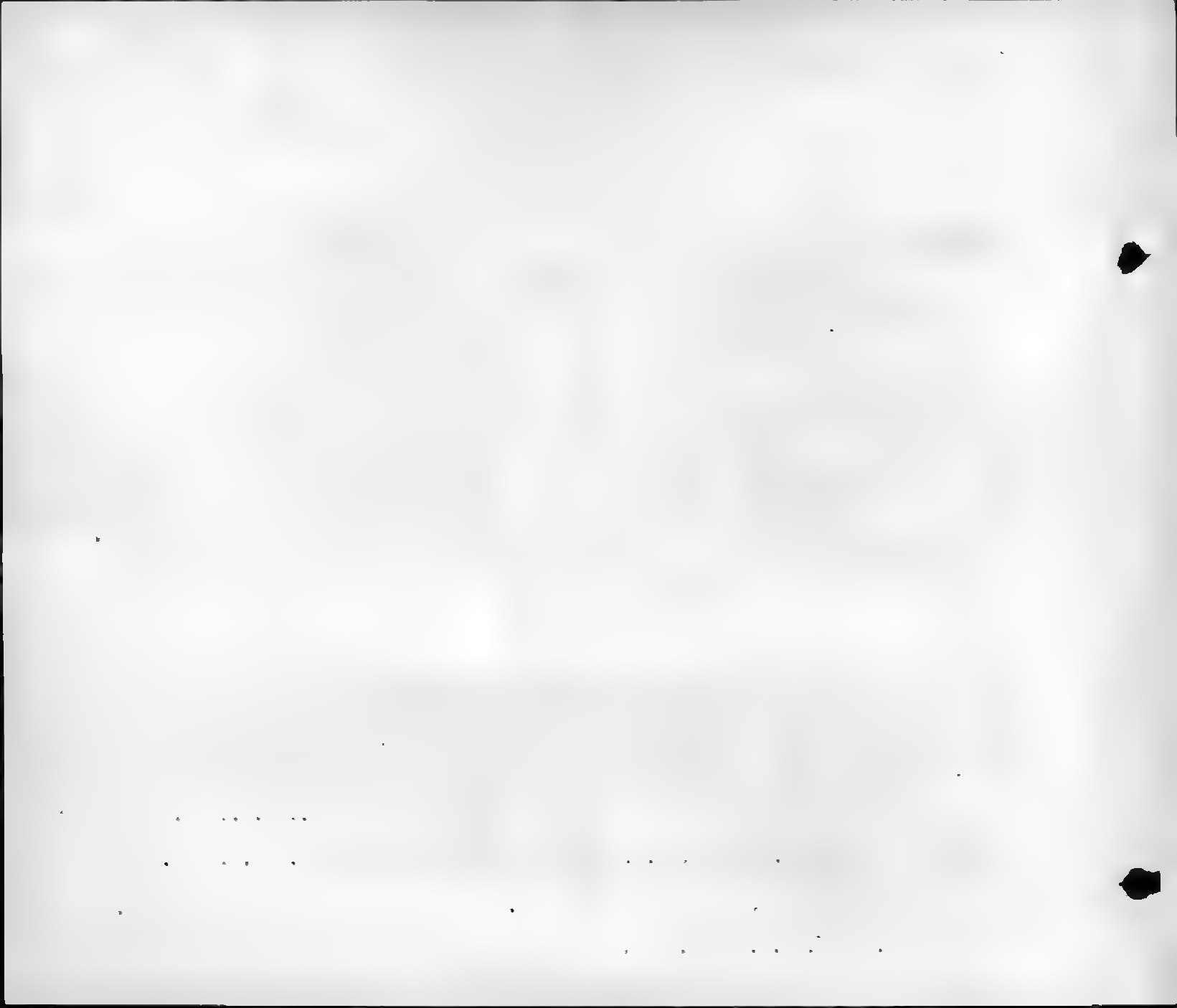


3495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>5902 - 85 - Place</u>			
3. NAME OF DECEASED (Type or print) <u>Infant Girl</u> First Middle Last <u>Tuma</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Girl</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1960</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u>52</u> Min. <u>41</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Stephen Tuma</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ann Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>76x</u> DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 2, 1960</u> to <u>March 4, 1960</u> that I last saw the deceased alive on <u>March 4, 1960</u> and that death occurred at <u>5:15a M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Herbert J. Jacobs M.D.</u> M.D. <u>10620 Georgia Ave., S.S., Md.</u> April 21							
PHYSICIAN'S NAME (Type) <u>Herbert J. Jacobs, M.D.</u> <u>10620 Georgia Ave., S.S., Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hospital Takoma Park Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. And Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton J. Miller</u>	



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

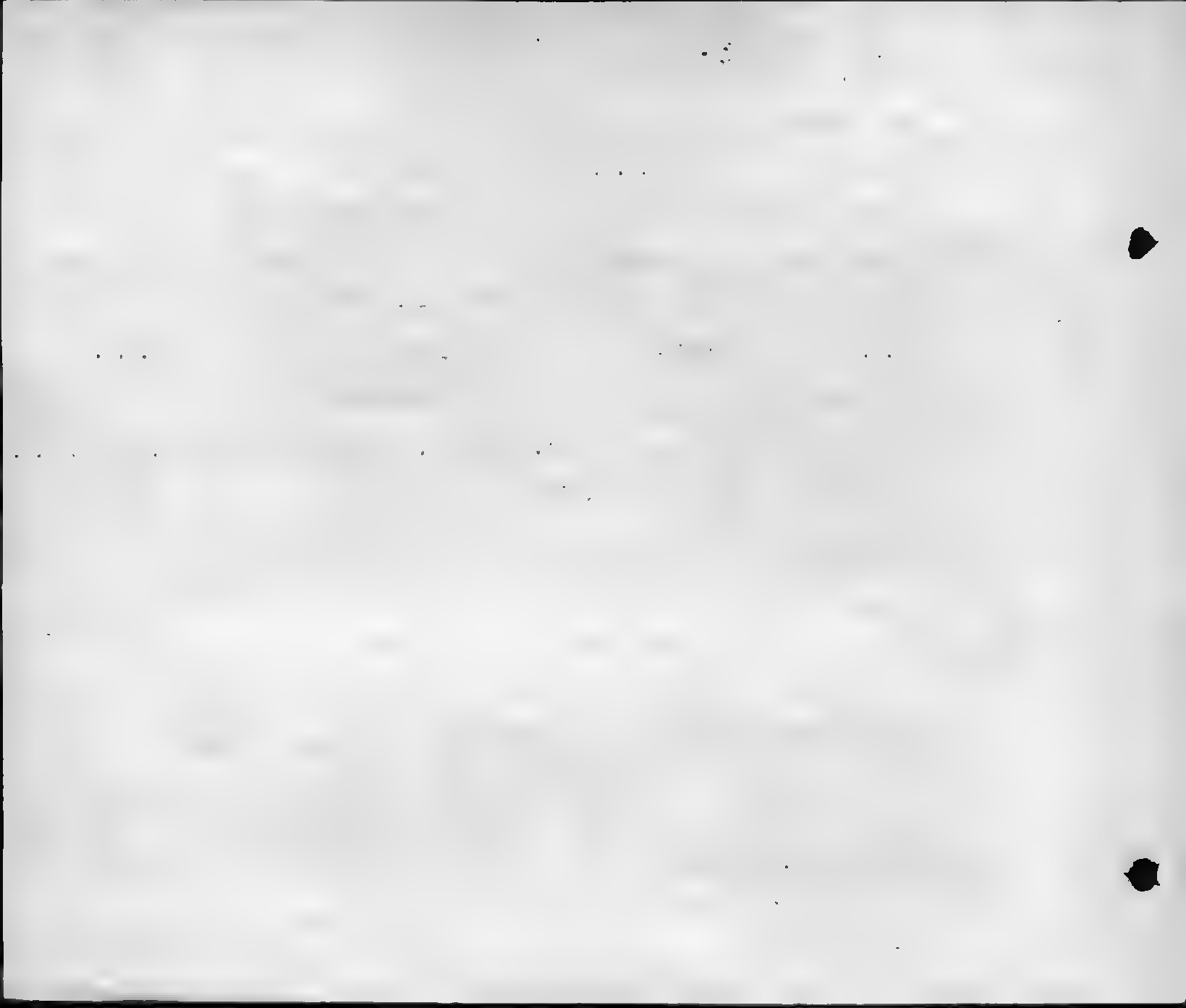
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**3651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03602

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>8 East Lennox Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry Morehead Underwood</b>		4. DATE OF DEATH <b>March 1 19 60</b>		5. AGE (In years last birthday) <b>66 yrs.</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Colonel U.S. Army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
13. FATHER'S NAME <b>Robert Underwood</b>		14. MOTHER'S MAIDEN NAME <b>Emma Younglove</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Lt. Andrew F. Underwood (nephew)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D.		DATE SIGNED <b>2 March 1960</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>3/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LEE'S CREMATORY</b>	
22d. LOCATION (City, town, or country) <b>Washington D.C.</b>		23. FUNERAL DIRECTOR <b>LEE FUNERAL HOME 300 4th ST NE</b>			
24a. REC'D BY REGISTRAR <b>MAR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>			

MEDICAL CERTIFICATION





3652

## CERTIFICATE OF DEATH

03603

Reg. Dist. No. 215

Page 4

VS A15 (4)  
ISM 9/58

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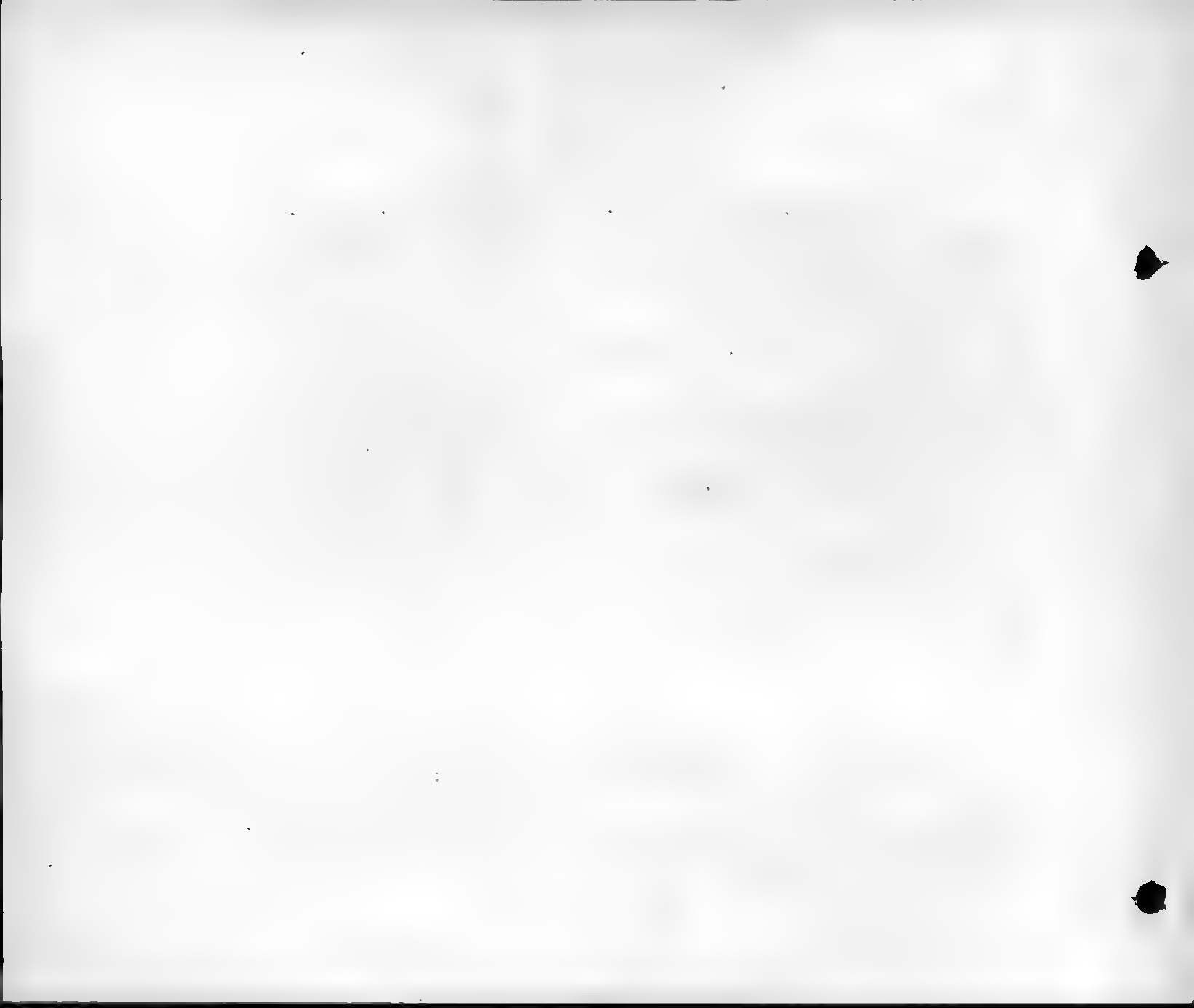
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter Victor Rudolph VIEWEG</b>				4. DATE OF DEATH Month Day Year <b>March 20 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-02</b>	
9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Rudolf VIEWEG</b>				14. MOTHER'S MAIDEN NAME <b>Emma KLEIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1924-1934</b>		INFORMANT <b>(Wife) Anna R. Vieweg</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Pulmonary Infection, chronic</b> <b>251X</b> DUE TO <b>anemia + Hyperkalemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal calcinosis &amp; failure</b> DUE TO <b>Parathyroid Tumor - functional</b> (c) <b>3+ mo</b> <b>6+ mo</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>3+ mo</b> <b>6+ mo</b>	
PART II OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE COND. TION GIVEN IN PART I <b>Hypertension &amp; Congestive Heart failure, thrombophlebitis, Right leg + An.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <b>Auto crash</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>23 February, 19 60</b> , to <b>20 March, 19 60</b> , that I last saw the deceased alive on <b>20 March, 19 60</b> , and that death occurred at <b>8:50AM</b> , from the causes and on the date stated above. - ADDRESS (Street, city or town, state) DATE SIGNED <b>Fred H C Council M.D. U.S. Naval Hospital, Bethesda, Md. 3-21-60</b>							
ACTUAL SIGNATURE <b>Fred H C Council</b>		PHYSICIAN'S NAME (Type) <b>F.H. O'CONNELL LCDR MC USN U.S. Naval Hospital, NNMC, Bethesda, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gawler's 1756 Pennsylvania Ave. N.W. Washington</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Gawler's 1756 Pennsylvania Ave. N.W. Washington</b>	



3653

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Margaret Rebecca Voigt</i>		4. DATE OF DEATH Month Day Year <i>Mar. 31 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 6, 1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Miller</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Burrows</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>NO</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Asystole</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>myocardial infarct</i> (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Pyelonephritis, Uremia, Essential Hypertension</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 25, 1960</i> to <i>March 31, 1960</i> , that I last saw the deceased alive on <i>March 31, 1960</i> , and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William Henry Killay</i> M.D.		ADDRESS (Street, city or town, state) <i>9902 Counselman Rd Bethesda 14 Md</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/4/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Washington DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chung Chuan Funeral Home Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 4 '60</i>	
ADDRESS <i>5703 14th St N.W.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information obtained by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use by the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



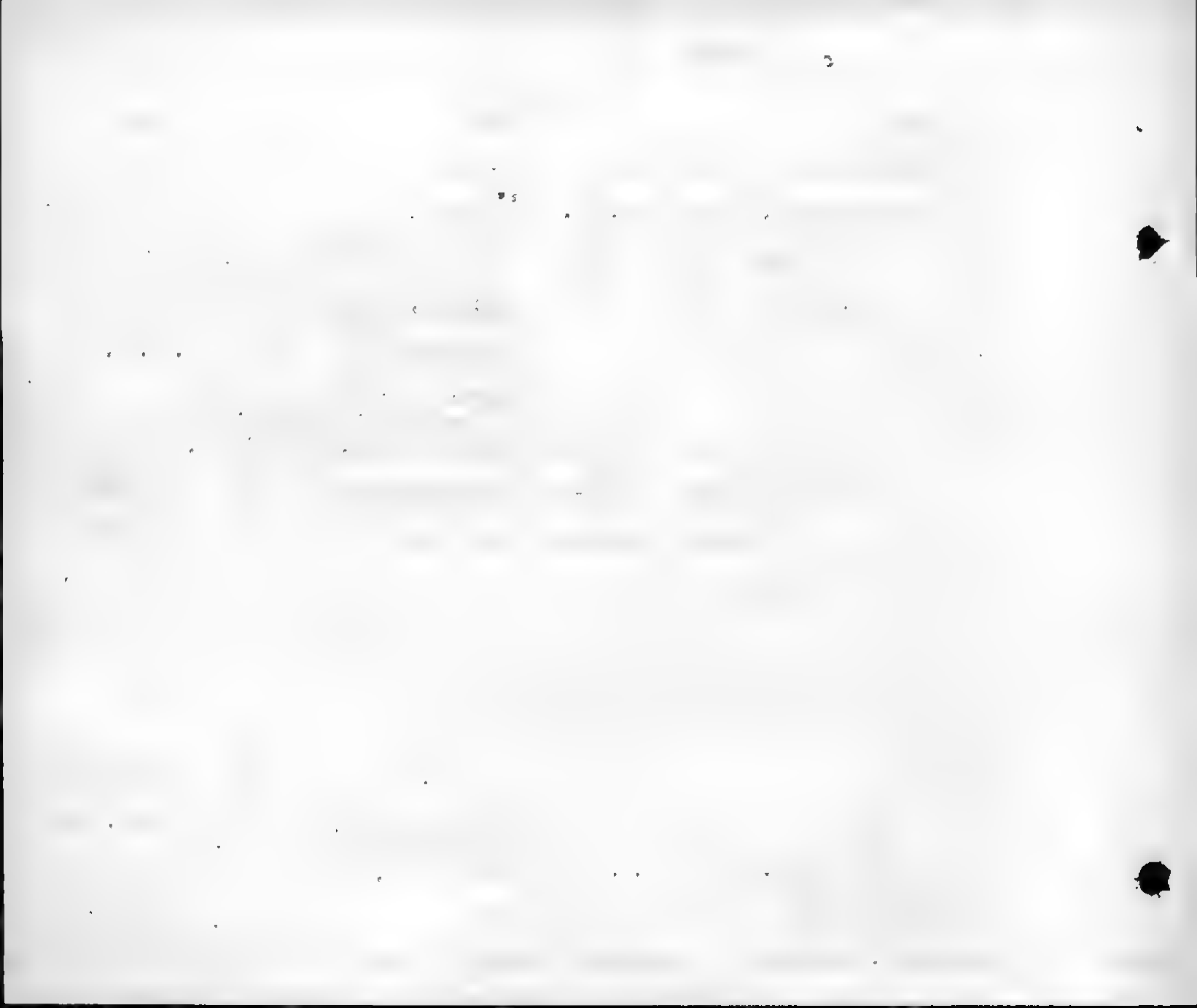
## 3654 CERTIFICATE OF DEATH

03605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Arkansas</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Almyra</b>		
c. LENGTH OF STAY IN 1b <b>23 days</b>			d. STREET ADDRESS <b>PO Box 215</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Faye</b> Last <b>Vos</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1950</b>		9. AGE (In years lost birthday) <b>10</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Calvin Vos</b>			14. MOTHER'S MAIDEN NAME <b>Eunice Roberts</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive gastro-intestinal hemorrhage</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Massive hemorrhage into lungs</b> DUE TO (c) <b>Acute leukemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 weeks</b> <b>21 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>February 8, 1960</b> to <b>March 2, 1960</b> that I last saw the deceased alive on <b>March 2, 1960</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3 Mar. 1960</b>					
ACTUAL SIGNATURE <b>Laurence A. Gaydos</b>		M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Laurence A. Gaydos, M.D.</b>		<b>National Institutes of Health</b>			
		<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>3/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Almyra Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Arkansas Co. Arkansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information obtained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

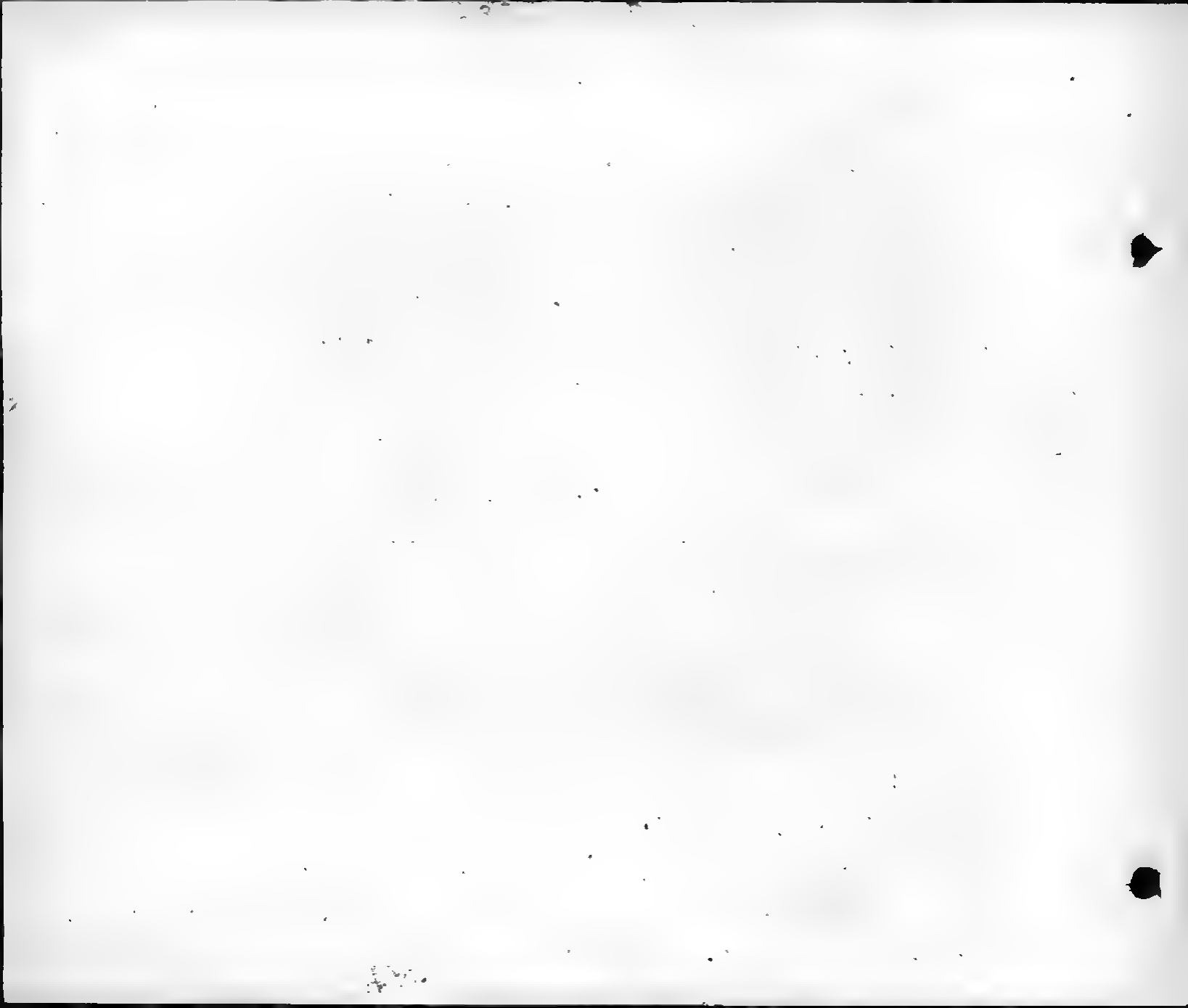
3655

## CERTIFICATE OF DEATH

Reg. Dist. No.

03606

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
f. STREET ADDRESS <u>13785 Howard Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1900</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u></u> Min <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN ADAMS WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHEER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>212-056564</u>	
17. INFORMANT <u>SON - Clifton Wagner</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>+34.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Pulmonary edema</u> DUE TO (c) <u>Compensatory heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1960</u> to <u>March 29, 1960</u> that I last saw the deceased alive on <u>March 27, 1960</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW</u> DATE SIGNED <u>3-29-60</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Humphrey</u>		24a. REC'D BY REGISTRAR <u>Mar 31 '60</u>	
ADDRESS <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





# FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Office of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

How 4/5/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03607

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dr. Bird Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mildred Bathne Watson</u>		4. DATE OF DEATH <u>Mar 20 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-1960</u>	
9. AGE (In years last birthday) <u>24</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Vernon David Watson</u>		14. MOTHER'S MAIDEN NAME <u>Deloris Hough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Deloris Watson (mother)</u>	
17. INFORMANT <u>Deloris Watson (mother)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sound</u>	
DUE TO (b) <u>upper Resp. Infection</u>		DEAD IN BED <u>Dead in bed</u>	
DUE TO (c) <u>cause lost</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DATE SIGNED <u>3-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant</u>		22d. LOCATION (City, town, or country) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3516

Item 2 Film 3258 3-15-60 at

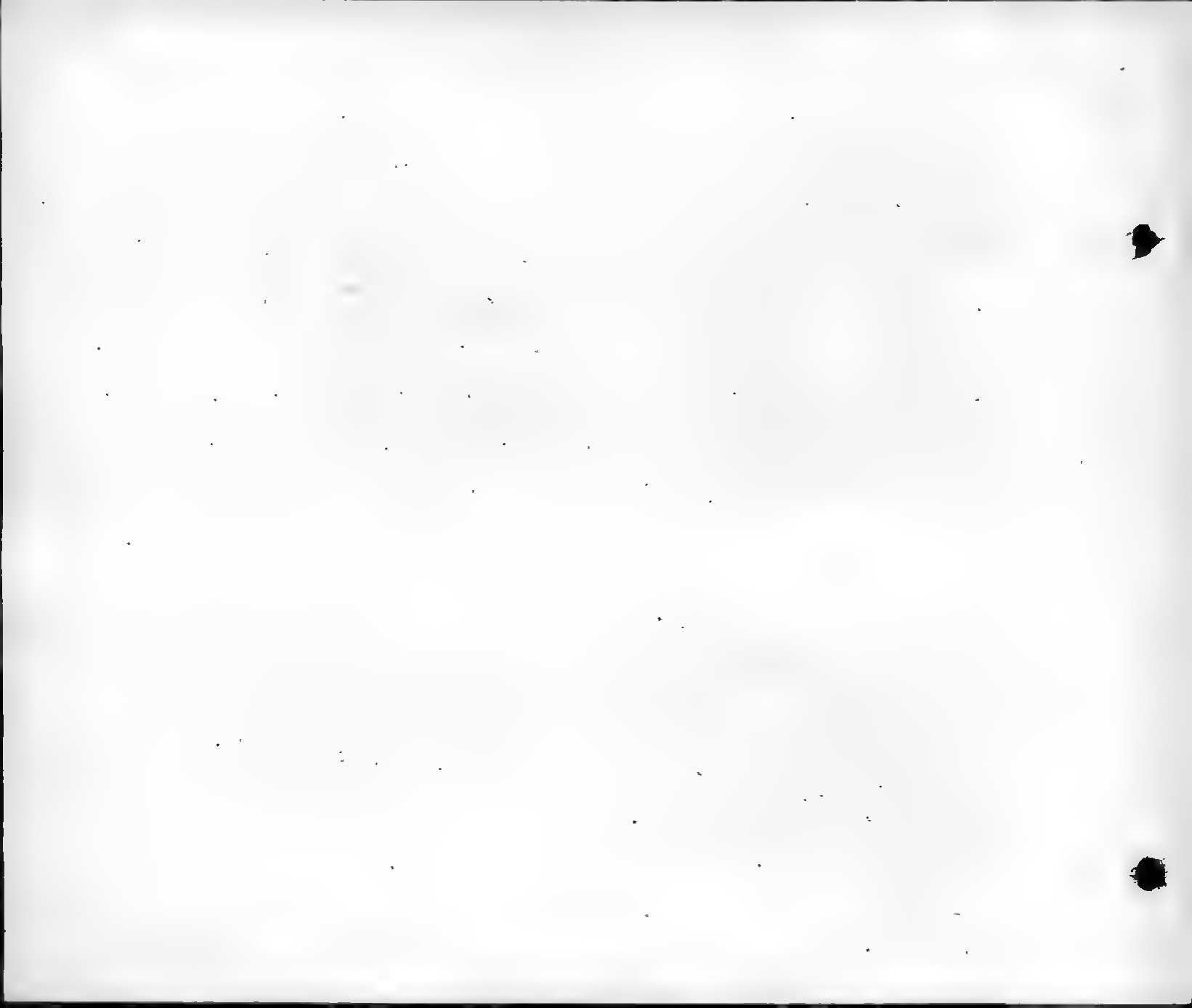
## CERTIFICATE OF DEATH

03608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on: Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>Rockville Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tipton Nursing Home</b>		d. STREET ADDRESS <b>1216 Baltimore Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LOUISA</b> Last <b>WHEELER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 5 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>7</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>ARLINGTON MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS GREATY</b>		14. MOTHER'S MAIDEN NAME <b>Helen MAUDE SNOW, NEW FOUNDLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-20-1132A</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertension</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>15-20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>8 MAR 1960</b> that I last saw the deceased alive on <b>9 Jul 1960</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>906 Walsville Rd 3/5/60</b> DATE SIGNED ACTUAL SIGNATURE <b>William D. Aud</b> M.D. <b>Shiner Spring Maryland</b> PHYSICIAN'S NAME (Type) <b>William D. Aud</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit 3/11/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockland, Massachusetts</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Fumphyrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> DATE <b>MAR 10 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57



## 3497 CERTIFICATE OF DEATH

Reg. Dist. No.

03610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salem Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sav &amp; Hosp</u>		e. STREET ADDRESS <u>2705 Finch St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JANE</u> <u>NNN</u> <u>Williams</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-89</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>James Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO <u></u>	
17. INFORMANT <u>St. Charles</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 400.1 DUE TO <u>Arteriosclerosis - Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteries</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Undetermined</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1st 1st 1960</u> to <u>Mar 18, 1960</u> , that I last saw the deceased alive on <u>Mar 18, 1960</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u>		ADDRESS (Street, city or town, state) <u>M.D. 10520 Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		DATE SIGNED <u>Mar 18, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawn Craft Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Del Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LIFE FUNERAL HOME</u>		ADDRESS <u>300 4th St NE</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>MAR 22 '60</u>		<u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be examined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 14 3-31-60 et

3455

Items 3,7,11,13,16,17 & 22, File G-150 4/11/60.cac

## CERTIFICATE OF DEATH

Reg. Dist. No.

03611

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>West Orange</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14511 Colesville Road</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Essex</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Orange</b> d. STREET ADDRESS <b>64 Whittingham Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAE</b> First Middle Last <b>Halliday WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>March 22 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>7/10/1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>8 12</b>	11. IF UNDER 24 HRS Hours Min <b>16 12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Halliday William Holladay</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Mary Laurence</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Williams-son-5822 Greenlawn Rd Drive</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-13, 1959</b> to <b>3-22, 1960</b> , that I last saw the deceased alive on <b>3-21, 1960</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John S. Rogers</b>		DATE SIGNED <b>3-22-60</b>	
NAME (Type) <b>John S. Rogers</b>		ADDRESS (Street, city or town, state) <b>1919 Seminary Rd. Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Orange, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. Edgar S. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3657

## CERTIFICATE OF DEATH

Reg. Dist. No.

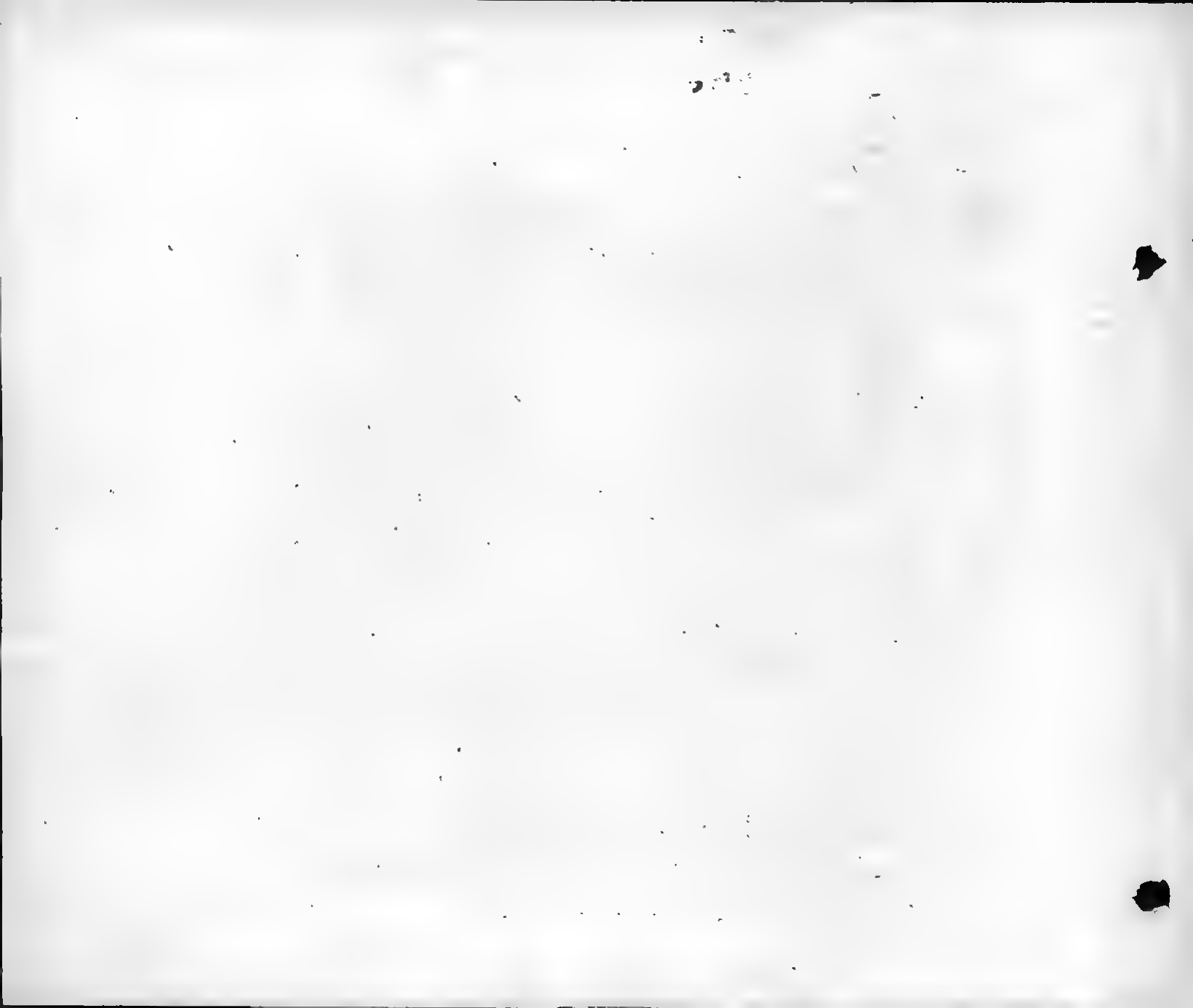
03612

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARGARET WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 16 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/18</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Frazier</u>		14. MOTHER'S MAIDEN NAME <u>Stet Nandy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>INFORMANT</u>	
17. NAME OF INFORMANT <u>Mrs Walter McRoy</u>		18. ADDRESS <u>204 21 1/2 Ave Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> <u>4'5X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Coronary</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Diabetes Mellitus - Bronchopneumonia double lung</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3.11.1960</u> to <u>3.16.1960</u> , that I last saw the deceased alive on <u>3.15.1960</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Stewart Crapp</u>		DATE SIGNED <u>3.16.60</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Crapp</u>		ADDRESS (Street, city or town, state) <u>Wash 15 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shawlen</u>		ADDRESS <u>Rockville, Md</u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

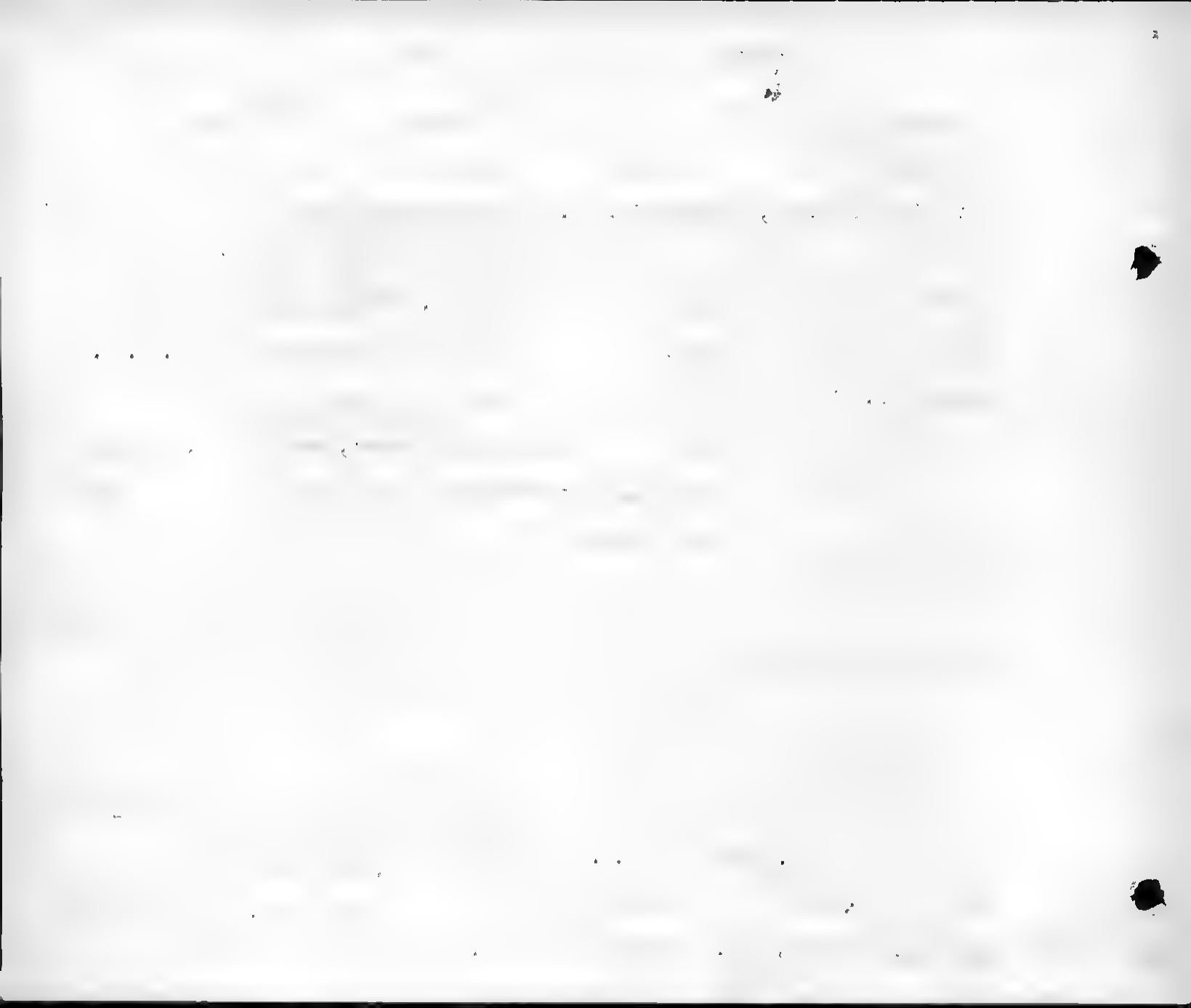


## 3658 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>4401 Oak Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Diane</b> Middle <b>Sada</b> Last <b>Witt</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1957</b>	9. AGE (In years last birthday) <b>2</b> yrs	IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Franklyn R. Witt</b>		14. MOTHER'S MAIDEN NAME <b>Thelma Stansbury</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>		INFORMANT Address <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Gastro-Intestinal Hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Leukemia</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Hours</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>March 1</b> , 19 <b>60</b> , to <b>March 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 6</b> , 19 <b>60</b> , and that death occurred at <b>1:15 P. M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3-6-60</b>							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>			
22d. LOCATION (City, town, or county)		(State)		<b>PRINCE GEO. COUNTY, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 9 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3659

CERTIFICATE OF DEATH

03614

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>57</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8102 Maple Ridge Road</b>		d. STREET ADDRESS <b>8102 Maple Ridge Road</b>	
3. NAME OF DECEASED (Type or print) <b>ANDREW W WOLTER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/1904</b>
9. AGE (In years lost birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months <b>3</b> Days <b>24</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>United Brick Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Andrew H. Wolter</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Frances Wolter-wife-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4:00 PM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Not Known</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1948</b> , to <b>March 2, 1960</b> that (I) (we) last saw the deceased alive on <b>March 2, 1960</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>W. T. Joyce</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>8102 Maple Ridge Rd, Bethesda, Md</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/10/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>MAR 10 '60</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT

Division 3660 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03615

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yarthurding</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yarthurding</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R40 # 2</u>				e. STREET ADDRESS <u>R40 # 2</u>			
3. NAME OF DECEASED (Type or print) <u>George Austin Young</u>				4. DATE OF DEATH <u>Mar 9 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Hours <u>70</u> Min. <u>70</u>		10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sampson Young</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Geo A. Young Jr.</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. (c) <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/14/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Frederick, Maryland</u>			
23. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son; Frederick, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>				DATE <u>3-9-60</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

3498

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03616

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Nicholas Rums</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Greek</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-67</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>			
11. BIRTHPLACE (State or foreign country) <u>Greece</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Nicholas Luras</u>				14. MOTHER'S MAIDEN NAME <u>Marie MANTZOURAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Marie Z. Harris</u>				Address <u>10435 Edgewood Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular D.</u> 177X DUE TO <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Carcinoma of Prostate</u> (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 <u>  </u> to <u>3/11</u> 1960, that (I) (we) last saw the deceased alive on <u>3/11</u> 1960, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Oliver E. Thompson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>				22d. ADDRESS <u>901 Pershing Drive, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/14/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 60</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>							

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MEDICAL CERTIFICATION

